The Modern Hospital

FEBRUARY 1958

PATIENTS' LOUNGE AT NEW NURSING HOME UNIT, PRINCETON HOSPITAL, PRINCETON, N.J. (Page 55)

Community Hospital, Indianapolis, Indiana. Daggett, Haegele & Daggett, architects; J. M. Rotz Engineering Co., mechanical engineer; Freyn Brothers, Inc., mechanical contractor; all of Indianapolis.

CONTROLLED ENVIRONMENT—*IT PAYS!*

The right temperature for every purpose—253 underwindow air conditioning units are individually controlled by Johnson Heating-Cooling Thermostats. The modern pneumatic control system eliminates time-consuming room temperature checks, helps safeguard patient health and comfort.

Citizens of Indianapolis can be justifiably proud of their beautiful new Community Hospital. With typical Hoosier self-reliance, they built and equipped a building that rates with the best, financing the entire $4.8 million project through popular subscription.

Among the building's many impressive features is its closely controlled thermal environment. Air conditioned throughout, it is equipped with a Johnson Pneumatic Temperature Control System that permits *individual room* control of temperatures throughout the hospital. Operating rooms have the added protection and safety of Johnson Humidity Control.

With *individual room* control, the system provides the necessary flexibility to meet each one of many varied temperature needs. It results in better care and greater comfort for patients, improves the overall working efficiency of the staff and assures important long range savings on heating and cooling costs.

When you build or air condition, let the specialist Johnson organization provide your hospital with a control system designed to produce equally successful results. A nearby Johnson engineer will gladly study your requirements and analyze for you, your engineer or architect the advantages of installing a Johnson Pneumatic Control System. Johnson Service Company, Milwaukee 1, Wisconsin. Direct Branch Offices in Principal Cities.

JOHNSON CONTROL

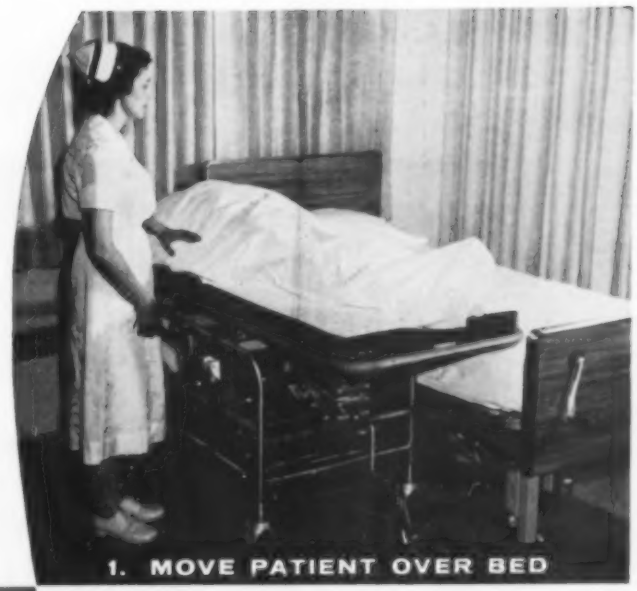
PNEUMATIC SYSTEMS

DESIGN • MANUFACTURE • INSTALLATION • SINCE 1885

Transfer your patients
easier, safer on

HAUSTED
"Easy Lift"
Wheel Stretchers!

Now all your patient transfers can be made quickly, safely and without strain on patients or staff, with Hausted "Easy-Lift" Wheel Stretchers.



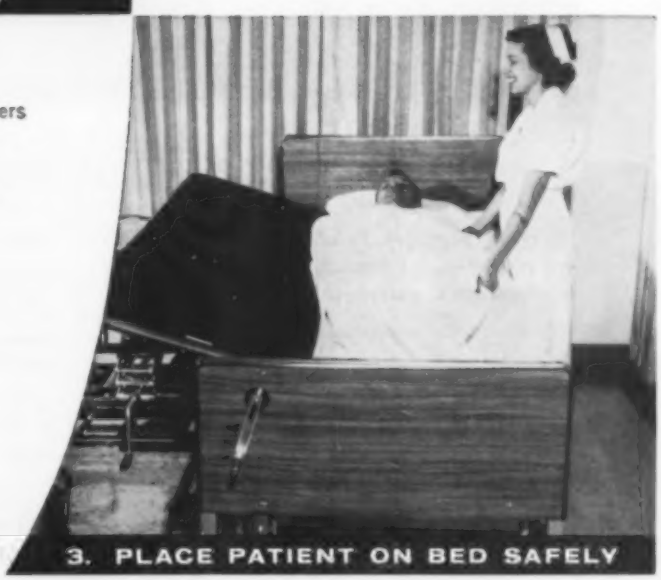
1. MOVE PATIENT OVER BED

2. TILT PATIENT TO BED

With Hausted "Easy-Lift" stretcher one small nurse can transfer a 300-pound patient by the easy turn of a crank.

Hausted "Easy-Lift" with the exclusive Two-Way Slide and Tilt feature will:

1. ***Move Patient over Bed***
2. ***Tilt Litter so It Locks into Mattress***
3. ***Transfer Patient to Bed without Disturbance***



3. PLACE PATIENT ON BED SAFELY

Thousands of Hausted "Easy-Lift" Stretchers are in daily use in hospitals all over the world. They are engineered for years of hard service. With available accessories, the "Easy-Lift" provides the ultimate in patient care for Emergency and Recovery use.

For complete data on all Hausted Wheel Stretchers, write

THE
HAUSTED
MANUFACTURING COMPANY
Medina, Ohio

The Modern Hospital

FEBRUARY 1958 VOLUME 90, NO. 2

Articles in this issue

Continued on next page ►

Editor, ROBERT M. CUNNINGHAM Jr. *Assistant to the Editor,* SHEPARD D. ROBINSON
Associate Editors, MILDRED WHITCOMB, JANE BARTON *Assistant Editor,* ANN M. UNDERWOOD
Advertising Director, J. W. CANNON Jr. *Chicago Advertising Offices:* 919 N. Michigan Ave., Chicago 11, Ill.
Eastern Office: 119 W. 40th St., New York 18, N.Y. *Cleveland Advertising Office:* 19030 Westlake Road, Cleveland 16, Ohio
Western States Advertising Representative: Bob Wettstein & Associates, Los Angeles, San Francisco

The Modern Hospital

Published monthly and copyright © 1958 by The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11, Ill., U.S.A. (Cable Address: Modital, Chicago.) Howard Barringer, president; Robert F. Marshall, executive vice president; Robert M. Cunningham Jr., vice president and editorial director; H. Judd Payne, vice president; J. W. Cannon Jr., assistant vice president; Stanley R. Clague, secretary; John P. McDermott, treasurer. Subscription price in U.S., U.S. Possessions and Canada, $4 a year and $6 for two years; elsewhere, $6 a year and $10 for two years. Single copies, $1. Member Audit Bureau of Circulations, Associated Business Publications. Entered as second-class matter, Oct. 1, 1918, at the Post Office at Chicago, Ill., under the Act of March 3, 1879. Printed in U.S.A.

READER OPINION

Credit for Nursing Article

Sirs:

I should like to take this opportunity to correct a misunderstanding in connection with the article "What Nurses Like and Dislike About Their Jobs," on page 53 of the December 1957 issue of The MODERN HOSPITAL. Whereas the footnote states that "This study was conducted . . . under the direction of Mary E. Brackett, R.N., associate director of nursing service," other people deserve far more credit for this.

Specifically, June Long, our supervisor and instructor of student practical nurses, was in charge of the project. Her relationship to this study was as chairman of the committee on staff education for supervisors. Miss Long spent many hours working on this and I think it was her perseverance that kept the whole thing going.

Mary E. Brackett, R.N.
Associate Director of
Nursing Service
Hartford Hospital
Hartford, Conn.

Author's Side of Five Sides

Sirs:

In the November 1957 issue of The MODERN HOSPITAL Mildred Lorentz has raised several points in answer to my article "The Five Sides of the Nursing Problem" which appeared in The MODERN HOSPITAL for July. Her article is worthy of serious consideration, being temperate and thoughtful throughout.

I would like to point out, however, several places where it seems to me that Miss Lorentz has emphasized only one aspect of a particular problem, overlooking or omitting other important aspects. She compares, for example, the number of active professional nurses per 100,000 people in 1940 and 1956 with the ratio of physicians and dentists during approximately the same years. The comparison would have had far more pertinence if she had compared the number of professional nurses in those years with the increased number of hospital beds and the tremendously increased demand for nurses in public health, school nursing, industry and armed forces, during that period. Nursing education, and consequently the recruitment of student nurses and the number of nurses graduated each year, has been almost completely under the control of nurse educators for many years, and it seems apparent that they have utterly failed to provide enough nurses to meet the rapidly increasing demand.

Miss Lorentz also points out that 67 per cent of all nurses are working with people who are ill—"the hospital or the doctor's office"—and draws the conclusion that therefore 33 per cent of all nurses should be prepared in baccalaureate degree programs or programs beyond the baccalaureate level. If there were no shortage of nurses, it can be assumed that a far greater proportion than 67 per cent of all nurses would be employed in patient situations. A study recently conducted in the hospitals of New York State shows a 33 per cent shortage of graduate nurses (6767 nurses) as compared with 10 per cent shortage in supervisory positions (232 nurses), and a 5 per cent shortage in teaching and administrative positions (47 nurses). This indicates that there is 26 times as great a shortage in the head nurse and general duty nurse

categories as there is in the supervisory and administrative categories. Statistics based on present employment of nurses, therefore, are bound to lead to an erroneous conclusion, as they have in this case.

Miss Lorentz also draws the conclusion that the 67 per cent aforementioned should be educated in "hospital or associate degree programs." It has been apparent in the past few years that the full weight of the National League for Nursing has been thrown into recruitment for the degree and the associate degree programs, as distinct from the hospital schools. There is a world of difference between the three-year hospital school and the two-year associate degree program, and I would hope that this distinction would not become blurred by lumping the two together in apposition to the baccalaureate program. The distinction should be between the hospital sponsored school on the one hand and the two collegiate programs on the other hand.

Miss Lorentz further draws the conclusion that higher standards of nursing education produce even more applicants and points out that student enrollment in diploma programs dropped from 39,513 in 1955 to 38,694 in 1956. At the same time she states that the student enrollment in basic degree programs, as compared to all nursing programs, increased from 5.6 per cent in 1946 to 14.9 per cent in 1956. These figures, of course, are not comparable, one being given in total number of admissions and the other in percentage of collegiate students to all nursing students. However, there has admittedly been an increase in the number of students enrolled in basic degree programs, and it is this factor which has given great concern to so many hospital administrators, because the gain in collegiate admissions appears to have been achieved at the expense of diploma school admissions, rather than representing new girls being drawn into nursing.

There is, of course, an increasing desire on the part of high school students to get a college degree, supplemented by pressures in the same direction from their parents. The largest single factor, however, in the swing from hospital to collegiate schools has been the widespread and highly effective propaganda of the National League for Nursing and other nursing education groups promoting the collegiate degree programs. At the same time these organizations have been carrying out an "aggressive program of school improvement," to quote Miss Lorentz, which has resulted in the closing of many hospital schools of nursing and the imminent closing of many more.

The number of nurses graduated from schools of nursing in the past few years has not increased, whereas it should have increased substantially each year in order to keep up with the increasing needs. The program of the National League for Nursing has shifted girls from hospital schools to collegiate schools, but has not increased the total number of nurses graduating each year. With a national mortality of around 35 per cent in schools of nursing, and with a mortality very much greater than that in collegiate schools, the number of new nurses available for nursing as graduates each year becomes an even more important figure than the number of students admitted.

Miss Lorentz states that "well prepared teachers and faculty members constitute the greatest area of nursing shortage, and increasing the number of students in our schools of nursing is directly contingent upon the availability of faculty members who possess the skills necessary to teach nursing."

I think that both of these statements are open to challenge, and

cite as evidence the study in New York State already alluded to, which showed that the shortage of general staff nurses (including head nurses) was 26 times as great as the shortage of teaching, supervisory, and administrative nurses. In addition, a study of 80 hospitals in New York State which operate diploma schools of nursing has shown within the past month that these schools could have admitted 20 per cent more students last fall than they were able to recruit, *without additional faculty or additional physical facilities*. Furthermore, a great deal of the alleged shortage of faculty members has been artificially created by imposing unnecessarily and unrealistically high standards upon schools of nursing with regard to the number of advanced degrees a nurse must obtain before she can be a teacher.

In my article I raised the question as to whether or not the three-year hospital schools might prosper better if they had an organization of their own, and were accredited by the Joint Commission on Accreditation of Hospitals rather than by the National League for Nursing. Miss Lorentz pointed out that a Council of Diploma and Associate Degree Programs was organized as part of the National League for Nursing several years ago, and implies that this is the type of organization I was recommending. The organization which I proposed, however, was for the specific purpose of distinguishing hospital schools from associate degree and degree programs, and would result in establishing responsibility for accreditation in an organization such as the Joint Commission on Accreditation of Hospitals which also has some over-all responsibility for the proper and adequate care of patients and the cost of nursing education to the hospital. It is perfectly apparent that the interests of the National League for Nursing, in spite of some lip service to the hospital schools, lie in the associate degree and baccalaureate degree programs of nursing education. Hospital schools will continue to lose ground and eventually be forced out of existence unless they can find some sponsorship which is fully aware of and sympathetic to the problems they are facing.

Thomas Hale Jr., M.D.
Director

Albany Hospital
Albany, N.Y.

Italian Lecture Tour

Sirs:

I have just returned from a trip to Italy where I delivered a cycle of five lectures. Among these, I spoke in Naples before the Faculty of Architecture of the University of Naples, and in Rome before the Italian Hospital Center and the Society of Italian Engineers and Architects, on the theme of the hospital program in the United States, where I explained the workings of the Hill-Burton Act, its execution and effects; the current emphasis on the programs for mental health and geriatrics; the system of volunteer insurance, and illustrated my lectures with slides taken mostly from The MODERN HOSPITAL.

The audiences were composed of faculty members, students, architects and doctors, and in Rome quite a few high officials of the Public Health agencies. From the comments and letters I received, I think the lectures were found very interesting to them.

The purpose of this letter is especially to thank you for the great help your magazine gave to me for this task, in furnishing me much important and interesting information, without which I am sure I couldn't have obtained the success I think I did.

Mario Bianculli

Bianculli and Palm
Architects
Chattanooga, Tenn.

"Room and Board" Misnomer

Sirs:

I have such a respect for your splendid magazine, The MODERN HOSPITAL, that I hate to see you use the term "room and board."

In most of our general hospitals today I believe that our charge for this item is more than room and board and constitutes cost for nursing care. Am I wrong in this regard?

In other words, in all of my service club and TV-radio talks, I am careful to use the term "room and care" and explain what that means so that when the patient pays his bill for "room and care" he understands that it is much more than "room and board."

For instance in your December issue on page 47, "Small Hospital Questions," at the bottom of the third column it refers to "raise the charge for room and board." In other places throughout the magazine I also notice that you use this term.

Another term that I see used sometimes is "free hospital care." Could we not coin another wording to avoid creating the impression among some people that hospitalization care can be free? We know that someone has to pay for it so why not term it something like "charity" or "cost of indigent hospitalization services"?

W. S. Murphy
Administrator

Good Samaritan Hospital
Lexington, Ky.

Hospitals Have to Sell the Idea That They Do Know Their Business

BY GORDON DAVIS

Gordon Davis

OUR old furnace died hard with noxious exhalations, and when it had huffed and puffed its last and a gentle interment seemed indicated, our furnace man called politely with hat in hand.

He was with us two hours. At the end of that time we knew more about furnaces, heating methods, domestic fuels, and related matters than we had ever considered it necessary or even desirable to know.

It was expensive, our new furnace, and no doubt part of the cost covered the personal call of our heating expert, but I'm still bragging about how much we got for our money. In fact, I hardly see how the job could have been done for so little.

While we were exchanging furnaces a friend was investing in some major surgery. His cash outlay was about half the cost of our furnace and it bought him a miraculous return to health, but he's still hollering about his hospital bill.

Let's forget for a moment that a hospital is a hospital and try to imagine how it would proceed if it offered a service that was hard to sell. Let's assume that we established a sales department as a top echelon activity patterned after the best marketing and merchandising programs of business and industry.

Our first tangible move might be to employ a force of representatives to call on all elective patients in advance of admission. Their function would be to describe our hospital, to explain its facilities and qualifications, to reassure the "customer," to answer questions, and to discuss financing.

Our next step might be to replace that bleak and unimaginative cell, the admitting office, with patients' reception rooms furnished by a psychologically perceptive decorator. These rooms would be comfortable, restful, pleasantly lighted, carpeted, perhaps enlivened with soft background music, planned with zealous regard for individual privacy.

We would need trained professional hostesses. From the time a patient entered the hospital until his discharge, his morale and comfort would be the concern of a particular hostess who would be his one stable contact among the myriads of hospital personnel. The hostess would handle the admission, call on the patient regularly, arrange the details of discharge.

Finally, we might even develop a systematic follow-up procedure to check on the patient's satisfaction after hospitalization.

Ridiculous, isn't it? Merchandising is an instrument of commerce. A hospital has neither time nor money for pampering human foibles and emotions. In any case, everyone knows that hospital services no longer need to be sold. The trouble sometimes seems to be quite the opposite.

It is nevertheless true that today's hospitals are hard against one of the most difficult of all sales jobs. This is the job of persuading the public that hospitals know their business, that they conduct it with great efficiency, that their costs are completely justified, that they regard each patient as an individual and not as just another "case."

There is nothing in hospital tradition to prepare our modern administrator for this job of salesmanship, although its urgency increases hourly. Yet preparation and experience are not so important as recognition of the need.

now

STERILE PACKAGED

BARDEX® FOLEY CATHETERS

READY FOR INSTANT USE
WITHOUT PROCESSING OR AUTOCLAVING

Saves time, labor and nuisance—no delays for processing and autoclaving, no problem of trying to anticipate and process in advance the sizes that may be needed. No waits at time of emergency!

Saves money—eliminates the costly steps of processing and sterilizing—gives a *known fixed* catheter cost.

Convenient—simplifies the catheter inventory control problem for Central Supply. Requisitions can be filled *at once*—the right size catheter, easy to open, sterile, ready for instant use.

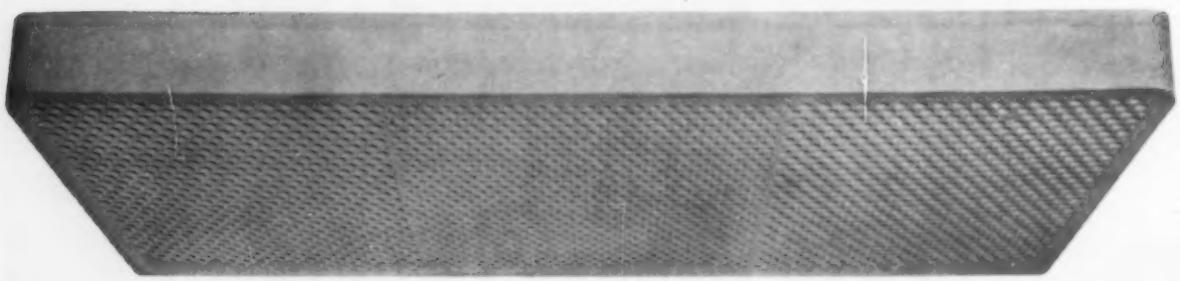
Write for illustrated brochure . . .

C. R. BARD, INC. • SUMMIT, N. J.

581

B.F.Goodrich

Only mattress with
certified compression and diagonal coring



B.F.Goodrich
Texfoam mattress

Two important things – compression and coring make the Texfoam latex foam mattress exactly the one your hospital should have.

Only B. F. Goodrich guarantees compression

The patented Texfoam Process makes latex foam differently than any other. Compression can be so completely controlled that B. F. Goodrich can guarantee *every* mattress will conform to exacting hospital standards.

B. F. Goodrich diagonal coring for easier handling

No splitting or creasing here – a Texfoam mattress can be folded, rolled and moved without worry. And it's so light and easy to carry; never needs turning.

Only B. F. Goodrich has real edge stability

A mattress edge is where support without stiffness is needed. B .F. Goodrich Texfoam mattresses put plenty of latex here but eliminate stiffness with two rows of ¼" cores. These are possible only with the patented Texfoam process.

There's a lot more that could be, *and needs to be* said about the new Texfoam mattress. It's the only mattress with all the advantages of latex foam and a lot more. So why don't you ask your present source all about it. Or write B. F. Goodrich Sponge Products, a division of The B. F. Goodrich Company, 419 Derby Place, Shelton, Connecticut.

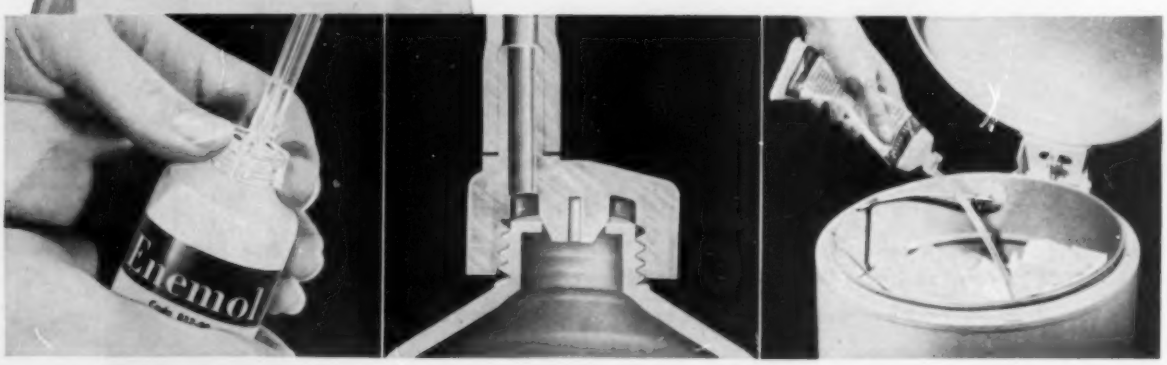
"Enemol makes giving enemas an easier chore"

It used to be that preparing and giving those routine enemas topped my list of "Most Unpleasant Nursing Chores." But, with Enemol — it's so much easier and faster that I don't mind it nearly as much.

The thing I like best about **Enemol*** is that there's no equipment to assemble or solutions to mix. Better yet, there's no messy equipment to clean up afterwards because you just throw the used container away. That means as much as 20 minutes saved — to spend doing something else.

Enemol ***is the only disposable enema*** I know of, with a shut-off valve you can easily open and close with a simple twist. You can even clear air from the tube before inserting. The tube, with its soft round top, is just stiff and long enough (6 inches) to insert easily without hurting the patient.

Having an enema is never pleasant, but Enemol makes it a lot less uncomfortable for the patient to take. That's because there are only 4½ ounces of fluid instead of the usual quart. And for routine enemas, this time-proven phosphate solution really does a better job than soap suds.



Enemol disposable Enema Unit

- *Saves nursing time*
- *Reduces expense*
- *Increases patient comfort*

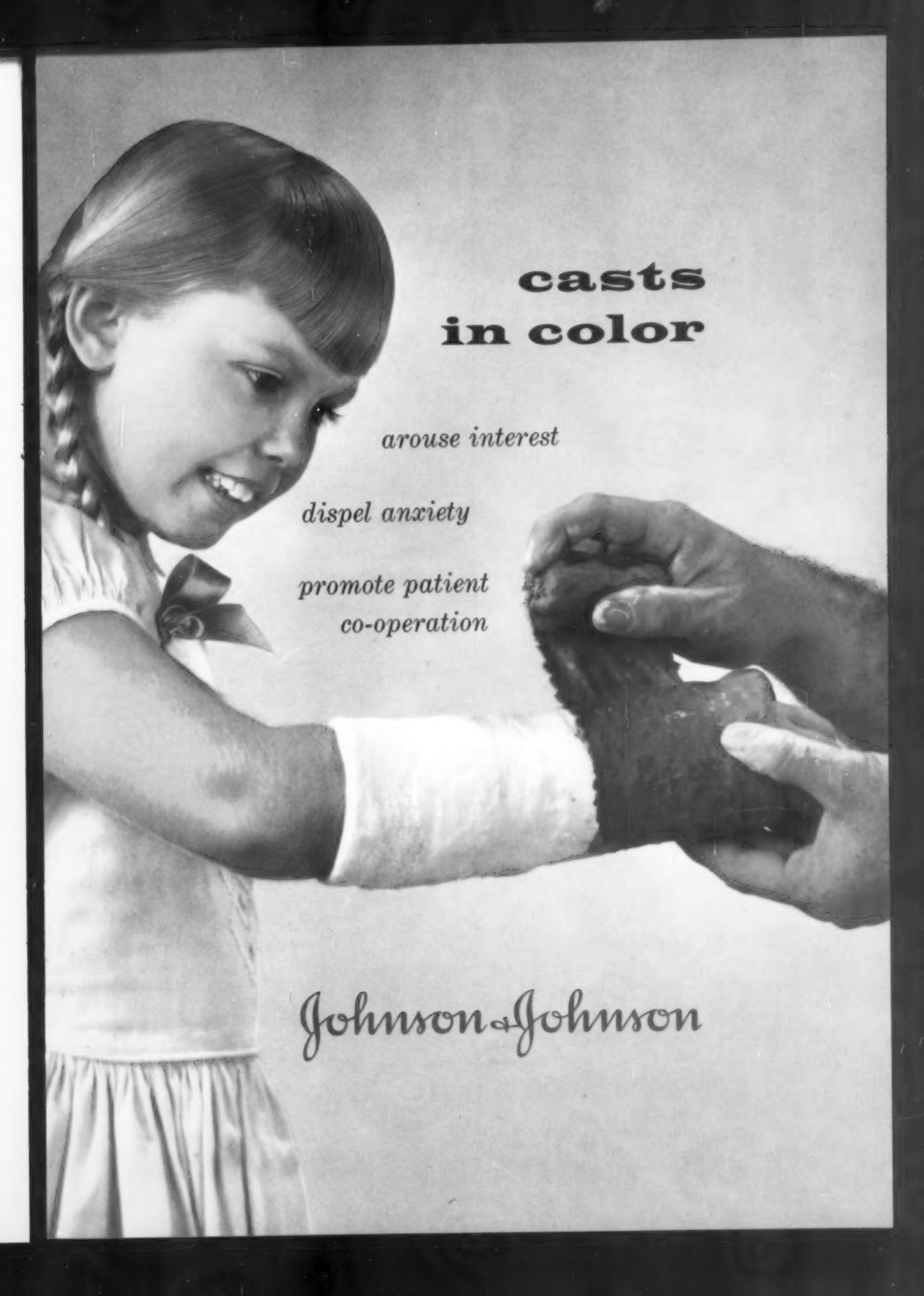
*TM

Packed in easy-to-handle cases of 24; 4½ oz. units.

60 *fine pharmaceuticals for 60 years*

1897 **CUTTER** *Laboratories*

BERKELEY, CALIFORNIA


casts
in color
arouse interest
dispel anxiety
promote patient
co-operation
Johnson & Johnson

"Specialist"®

COLOR-CAST Plaster Bandages

made with

PURE, SAFE, NON-TOXIC COLORS

Bright colors are ideal for all casts on children — soft yellow and flesh tones appeal to many adults.
SPECIALIST Color-Cast Bandages may be used throughout the cast or for the final covering layers of any white cast.

Available in 3" and 4" widths in either assorted colors or all flesh-tone. Assortments contain three red, three blue, three yellow and three flesh-tone.

Johnson & Johnson

Now everybody's talking...

about... *closer control of cross infection in every part of the hospital*

Wider recognition of the current problem of hospital-acquired infections is focusing new attention on ways and means of reducing this hazard to good patient care. Hospital and medical society meetings—and hospital, medical and surgical journals—are daily shedding new light on the varied aspects of the overall problem.

In many hospitals, a special "committee on cross infection" has been appointed to review practices and procedures. In others, each department head is studying closely his or her own methods of operation. Few hospitals exist which are not giving some special thought to this highly current problem.

Out of this critical evaluation has grown an awareness that environmental asepsis is a major weapon for cutting cross infection to a minimum. Application of continuous disinfection procedures from operating rooms through food service and laundry areas can be the means to changing the hospital's entire experience with hospital-acquired respiratory, intestinal, urinary or post-operative wound infections.

Take floors, for instance

Floors offer a great opportunity for furthering the spread of infection. Microorganisms settling to the floor are redispersed on dust particles or tracked through the hospital on shoes. Walls and ceilings as well can be reservoirs of potential infection. Lehn & Fink disinfectants not only kill all the most common pathogens on contact but are continuously active against new contaminants touching the disinfected surface for as long as a week later.

While the patient is there

Concurrent disinfection is practical whether or not the patient is "isolated." Wiping of furniture and fixtures and damp mopping of floor, with a disinfectant, stop air- and floor-borne microbes at the source.

In the operating room

Lehn & Fink disinfectants have many applications here. Among them: mopping floors; cleaning grills, ducts, and coils of air conditioners; as standard equipment on the scrub-up cart; as a germicidal dip to remove gross contamination from gloves before their removal; to gather instruments into enroute to sterilizer.

Other L & F disinfectant applications are many: for disinfection of instruments with lens systems, to wipe and store thermometers, to sanitize utensils, etc. In all instances, action is bactericidal, fungicidal and tuberculocidal.

Which L & F disinfectant?

Lysol®, O-syl® and Amphyl® do the same disinfecting job. Any one of them kills bacteria, fungi, and TB bacilli efficiently, but each has individual characteristics.

Lysol was far ahead of its time when introduced over sixty years ago. Recently the formula was improved; the odor was lightened and toxicity was reduced so that the "poison" label is no longer needed. Many hospitals prefer Lysol because of its long reputation for dependability. The characteristic odor is preferred by many for psychological reasons or as an indication that disinfection with Lysol has just been done.

O-syl is preferred by hospitals wanting all the germicidal efficiency of Lysol but without the odor. It is practically odorless when diluted for use. Like Lysol, O-syl is highly concentrated. Only a 1% solution of either (1 part to 100 of water) is needed for most applications.

Amphyl is also odorless when diluted for use. Convenience and low cost due to its high concentration often make Amphyl the disinfectant of choice. Amphyl is twice as powerful as Lysol or O-syl but does not cost twice as much. A ½% solution (1 part in 200 of water) is sufficient for general disinfection so that the cost per gallon of "use dilution" is less than with Lysol or O-syl. When expected contamination is great, as in TB or isolation wards, Amphyl is often preferred.

Let's talk about it

Solving the problem of environmental infection has been the business of Lehn & Fink since 1874. Solving such problems arising in your own hospital usually takes more than talk—but perhaps you would like to discuss them with our technical specialists. We can function as a part of your "committee on control of cross infection," perhaps suggest procedures, and supply informational material for teaching purposes. At any rate, please ask us. Specially trained field service representatives as well as the technical staffs in our New York office and in our laboratories at Bloomfield, New Jersey, are available for consultation.

• • •

Lehn & Fink disinfectants are available through your surgical supply dealer.

If you want literature, samples, or assistance in setting up procedures, please write:

Lehn & Fink *Professional*
PRODUCTS CORPORATION DIVISION
445 PARK AVENUE, NEW YORK 22, N.Y.

SPECIALISTS IN ENVIRONMENTAL ASEPSIS
®T.M. REG.

Ten years ago Hartford Hospital pioneered in the use of piped medical gases for anaesthesiology. Schrader cooperated with the hospital in design and production of safety-keyed outlets. Today, this system is still operating efficiently.

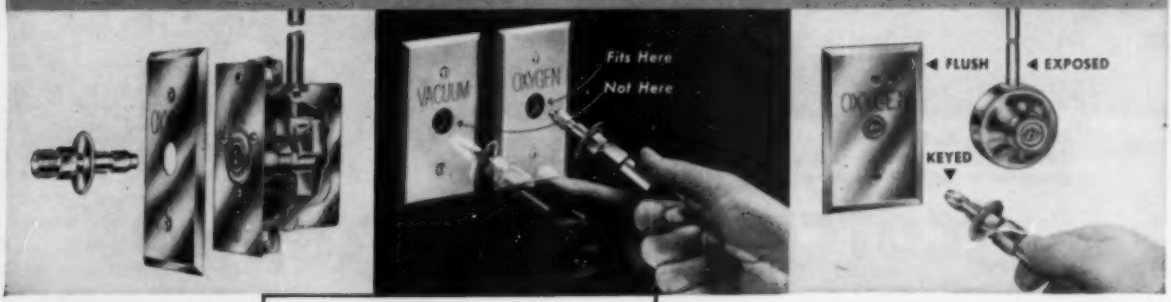
Schrader medical gas outlets have served ten years... dependably, safely, conveniently

Medical gas plug-in systems were pioneered by Schrader in cooperation with the Hartford Hospital a decade ago . . . these fittings are still in use today.

In the years since the original Hartford installation, Schrader has continued to design new and improved equipment for piping medical gases. Today, hospitals can have either Schrader safety-keyed flush-mounted or exposed outlets for oxygen, nitrous oxide, vacuum and air. You can't plug the adapter into the wrong unit. For added safety, each outlet is color keyed for the gas handled.

The new Schrader outlets can be coupled or uncoupled by a single-handed operation. Just plug in lines, or disconnect, with one motion. They're as easy to install as electric outlets. Either type will be shipped complete and ready for installation after complete inspection test. Write for further details.

LATEST SCHRADER SAFETY-KEYED OUTLETS FOR MEDICAL GAS PIPING NOW AVAILABLE



A. SCHRADER'S SON
Division of
Scovill Mfg. Co., Inc.,
470 Vanderbilt Avenue
Brooklyn 38, N. Y.

Schrader
a division of **SCOVILL**

FIRST NAME IN SAFEST
MEDICAL GAS CONTROL OUTLETS

new hospital furniture . . . by THONET

provides a home-like atmosphere

Warm and friendly wood hospital furniture by THONET brings a reassuring suggestion of home into the hospital room. Functional and contemporary in styling . . . engineered to meet the requirements of efficient hospital operation, this 800 group is available as a complete room, or as single pieces to meet your every space requirement.

#1006 High back chair

#7001 Over-bed table

#803 Bed

#701 Footstool

#824 Bedside-Chest

#833 Dresser Desk

#1294 Side chair

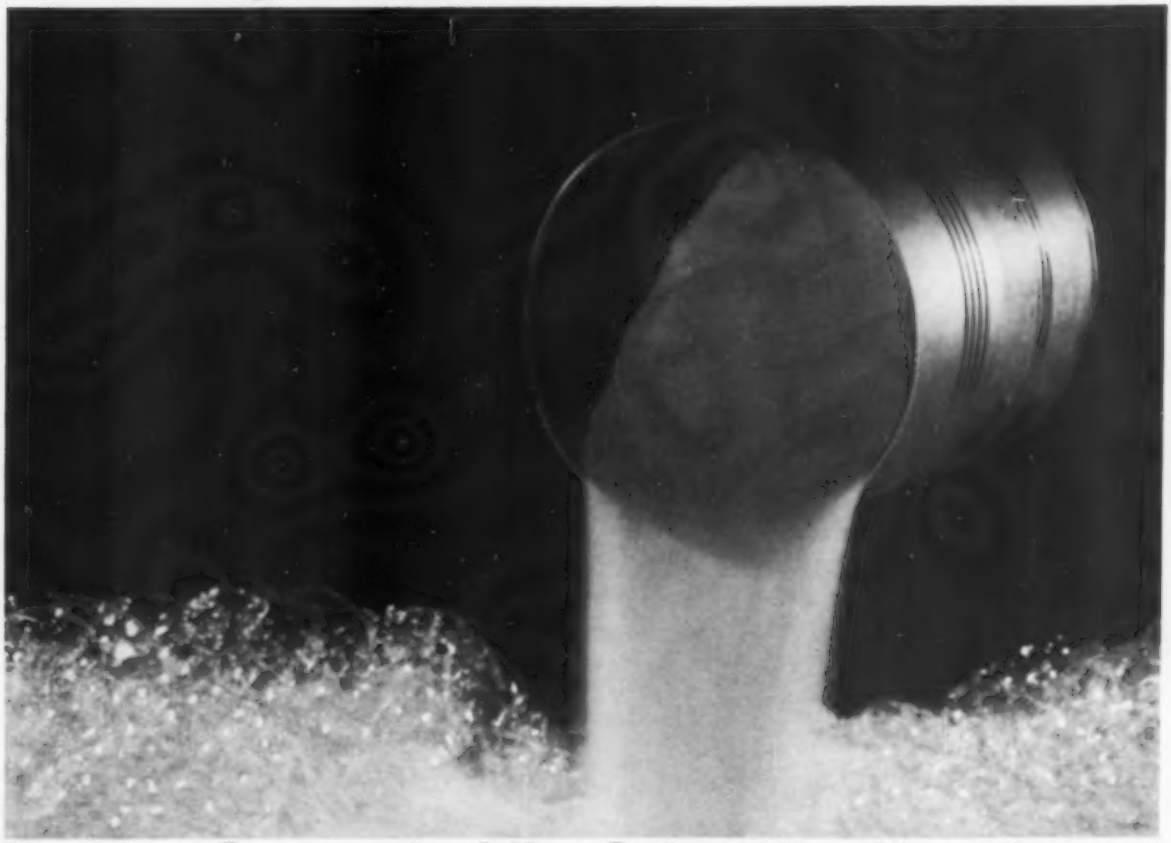
THONET INDUSTRIES, INC.

Write today for our illustrated folder H-800, Dept. K

THONET INDUSTRIES, INC.
One Park Avenue, New York 16, N. Y.

SHOWROOMS IN: NEW YORK, CHICAGO, LOS ANGELES, DALLAS, STATESVILLE, N. C.

Nothing Fails Like Guesswork!



Nothing Succeeds Like Scientific Cleanliness!

Solu-matic "20" adds compound *automatically!*

FROM EL RESEARCH CHEMISTS

Easy Way to Get More Work from Less Detergent!

Solu-matic "20" offers the most advanced detergent concentration control ever offered! Adds compound as needed to wash water, independent of operator! Equally effective in large or small establishments. Stainless steel prevents corroding, keeps it easy-to-clean. Uses less electricity than a 25 watt bulb and fits any dishwasher.

FROM EL DISHROOM ENGINEERS

Easy Way to Spot Hidden Costs!

The findings of modern science have eliminated guesswork in dishrooms. Trained EL Dishroom Engineers can spot costly errors others never see. Their work recently saved one well-known operator over $3,000 a month. Let them help you save money and protect your reputation for cleanliness. No charge, of course.

ECONOMICS LABORATORY, INC.

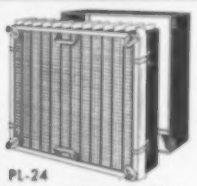
In Canada, Economics Laboratory (Canada) limited ★ *In Sweden,* Soilax AB

Domestic and Latin American Sales Offices: 250 Park Ave., New York 17, N. Y.


HOSPITAL AIR THAT'S

Oklahoma Medical Research Foundation, Oklahoma City. Architects and engineers: Caston-Frankfurt-Short, Oklahoma City; Mechanical Contractor: J. J. Bollinger Construction Company, Oklahoma City.

Electro-Matic
Electrostatic Precipitator



PL-24
Renewable-media Filter

HOSPITAL CLEAN!

For a building that houses medical research laboratories and a small hospital, ordinary "clean" air isn't clean enough. The air must be *super-clean . . . hospital clean!* And the air in Oklahoma City's Oklahoma Medical Research Foundation is just that, thanks to clean-air engineering by AAF.

Two types of AAF air filters—Electro-Matic and PL-24—are filtering ventilation air throughout the building. The Electro-Matic is an electrostatic precipitator that removes even smoke from the air, and automatically cleans itself at the same time! The PL-24 is a unit filter featuring low-cost renewable filtering media. It's the world's most efficient mechanical filter for ventilating and air-conditioning service.

AAF makes a *complete line* of filters. This assures you of the *efficiency you need* plus the *maintenance characteristics you want*. For further information, call your nearby AAF representative or write direct.

AAF
Herman Nelson

American Air Filter
COMPANY, INC.

415 Central Avenue, Louisville 8, Kentucky
American Air Filter of Canada, Ltd., Montreal, P. Q.

Air Filters and Precipitators

Illinois Heating Specialties

— BETTER AIR IS OUR BUSINESS —

Herman Nelson Console Heaters

AAF Dust Control Equipment

NOW AVAILABLE

Admiral. SDS

Sterile Disposable Syringe

TO HOSPITALS IN THESE AREAS

CHICAGO
Clark Linen & Equipment Co.
303 W. Monroe Street

CLEVELAND
The Kane Co.
1666 E. 40th Street

DALLAS
Admiral Hospital Service Distrib.
6710 Snider Plaza

DENVER
Admiral Distributors
1140 W. Fifth Avenue

DETROIT
Disposable Syringe Corp.
1249 Griswold

EAST HARTFORD, CONN.
The Southern New Eng. Dist. Corp.
619 Connecticut Blvd.

FARGO, N. D.
Dakota Electrical Supply Co.
1023 4th Avenue N.

FORT WAYNE, IND.
The Place Inc.
254 W. Main Street

INDIANAPOLIS
Capital Appliance Distributors
1201 W. Washington Street

KANSAS CITY, MO.
Lee Wholesale Co.
2109 Broadway

LOS ANGELES
Admiral Distributors
6565 E. Washington Blvd.

MINNEAPOLIS
George Spencer Inc.
444 Stinson Blvd.

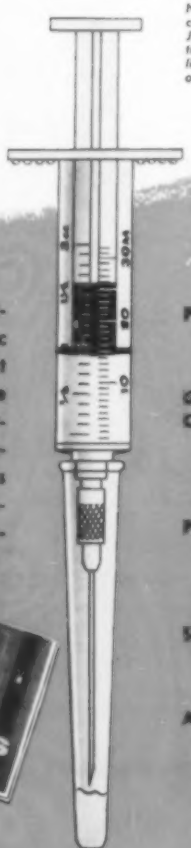
PORT CREDIT, ONT.
Canadian Admiral Sales Ltd.
501 Lake Shore Road

SAN FRANCISCO
Admiral Distributors
495 Beach Street

SEATTLE
Amberg Hospital Division
902 First Avenue S.

WASHINGTON, D. C.
Admiral Distributors
2046 West Virginia Avenue, N.E.

NOTE: The above list is complete as of press date, Jan. 2. Names of additional distributors, established since Jan. 2, sent on request.



Use once and Discard

WHY DISTRIBUTION IS LIMITED

Admiral realizes that every hospital adopting this modern technique for hypodermic injections must have absolute assurance that adequate supplies of the Admiral SDS are at all times available for immediate delivery, in the types and sizes required. Constant availability is assured in the areas listed above through distributors maintaining adequate stocks including a safety-margin reserve.

PREVENTS CROSS INFECTIONS
Both needle and syringe are used once only—and then discarded

GUARANTEED NEEDLE CLEANLINESS
Needle is guaranteed clean—guaranteed sterile. "Needle tatoo" cannot occur

PATIENT COMFORT ASSURED
Needle is factory sharp—eliminates possible use of dull or burred needle

SINGLE RING PLUNGER
Cannot trap air in the barrel—absolute sterility is assured

ALL TYPES AND SIZES
Intramuscular, intravenous, subcutaneous, Serology, Tuberculin, Insulin—in all gauges, needle lengths and calibrations

WATCH FOR announcements of other areas where the Admiral SDS will soon be available.

WRITE FOR INFORMATIVE BOOKLET and price list

Admiral Corporation
HOSPITAL SERVICE DIVISION
P. O. BOX 338—WEST CHICAGO, ILLINOIS—Telephone: WEST CHICAGO 1140

you'll always buy stainless steel

Add the low yearly maintenance cost to the initial price.

Then, divide the total by the *many years* of active service you enjoy with stainless steel.

RESULTS: YOU SEE THAT SHAMPAINE STAINLESS STEEL EQUIPMENT COSTS YOU LESS THAN ANY OTHER TYPE

Shampaine COMPANY

1920 S. Jefferson St. Louis, Mo.

THE WORLD'S MOST COMPLETE LINE OF STAINLESS STEEL SURGICAL EQUIPMENT

Serve your meals WITH Shampaine ELECTRIC

Super-Mealcart. (Design Pat. Pending) (S-3010-MR Illustrated 20 Trays with Beverage Bar S-3010)

SUPER-MEALCART

Represents the latest advance in efficient portable food service equipment for centralized tray systems. The famous step-down feature (design pat. pend.) provides work surface for set-up and beverage dispensing from exclusive removable beverage bar (S-3010). Large drawers with generous clearance allow room for half-pint milk containers and full complement of dinnerware. Drawer depth in hot side permits clearance for coffee cups. Coffee is dispensed from beverage bar into pre-heated cups. Available in *mechanical refrigeration* and *cartridge type refrigeration* models.

MECHANICAL REFRIGERATION MODELS

Mechanical refrigeration with hold-over cooling capacity for a full hour *without* running compressor or blower. Will hold and retain 38° F. even in room temperature of 90° F.

S-3001-MR	(20 trays)
S-3002-MR	(24 trays)
S-3003-MR	(30 trays)

CARTRIDGE TYPE REFRIGERATION MODELS
(CARTRIDGES NOT INCLUDED)

S-3001-DP	(20 trays)
S-3002-DP	(24 trays)
S-3003-DP	(30 trays)

ONLY SHAMPAINE ELECTRIC SUPER-MEALCART HAS . . .

- an unobstructed set-up area *convenient* counter height, at 41″ for 20-meal cart, at 44″ for 24-meal cart. Accommodates large trays up to 15½″ x 20¼″.
- all stainless steel, double-walled, fully-insulated construction throughout. 2½″ insulation between hot and cold compartment.
- compact heated drawers accommodating three 9″ dinner plates, *plus* three 5½″ plates, *plus* three coffee or tea cups
- an oven compartment with internal, waterproof installed, stainless steel, sheathed sealed heaters. Accessible *without* dismantling or turning cart upside down. Provides uniform temperatures (185° F.) throughout compartment.
- fully-insulated, recessed and double-walled doors of oven compartment close tightly against recessed frame. Full-length *stainless steel* piano hinges on doors.
- rugged, compact tray slides that can be removed in easy to clean *sections*, providing clearance between tray slides of 3¼″ for ½ pint "carton-type" milk container.
- models in 20, 24 and *30-meal size, for both *mechanical* and *eutectic* refrigeration (Dole cartridge), and with or without beverage dispensers.

*at additional set-up charge.

S-3010 Beverage Dispenser
(Cart Not Included)

REMOVABLE BEVERAGE BAR S-3010

Removable, easy to load, easy to clean beverage bar with *separate*, individually insulated wells permitting dispensing of boiling water from one and cooled drinks from the other. Bar can be used in combination with utility truck for "between-meal" coffee or fruit juice servings to patients or can be set up in Doctors Lounge.

Electric, three well—each well individually thermostatically controlled, stainless steel.

SHAMPAINE ELECTRIC COMPANY, INC. *THE COMPLETE FOOD CONVEYOR LINE*

50 Webster Ave. • New Rochelle, N. Y.

"Our Otis ELEVATORS are patients, staff and visitors

THE
NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL
THE PIONEER POST-GRADUATE MEDICAL INSTITUTION IN AMERICA
Organized 1881

"We cannot overemphasize the importance of elevators in this institution," says VINCENT CARISTO, Trustee. "They're the main arteries of our building.

"You can evaluate the importance of our 4 OTIS Elevators by understanding the service they must provide. The NEW YORK POLYCLINIC Medical School and Hospital is located in the heart of New York City close to one of its most congested districts. Ours is a closed hospital. It is a school for post-graduate medical instruction and a hospital that cares for 450 patients and a very large out-patient department. We have nine operating rooms on the 10th floor.

"You can well imagine what disrupted elevator service would mean to us.

"Until three years ago we experimented with various types of elevator maintenance without success. Then we put our 4 OTIS Elevators under OTIS Maintenance. Since then we have had no difficulty. Today we are happy and proud to recommend OTIS Maintenance. It's a hospital's assurance of peak performance at all times—for just one fixed, reasonable monthly charge."

VINCENT CARISTO, *Trustee*

Otis maintenance
that keeps elevators running like new

"ENGINEERED SERVICE BY THE MAKER"

Only Otis Maintenance offers these advantages to owners of Otis Elevators

- "Engineered Service" by the maker maintains the original efficiency of the installation and assures peak performance at all times.
- Services of factory-and-field trained men with a knowledge of elevatoring that can't be matched.
- Availability of original or improved replacement parts for every installation, regardless of its age.
- Freedom from unexpected, expensive repair bills. There's just one fixed monthly charge. It can be budgeted. It's adjusted annually, up or down, on labor and material costs only. Never because of the age or condition of the equipment.
- Guarantee of the maker's high standards of safety through the constant checking and replacing of parts in advance of their breakdown point.
- Elimination of all guesswork in testing and repairing by using specially designed tools and electronic equipment to minimize shutdowns.
- Systematic upkeep and replacement of parts extends the life of an installation indefinitely.
- The value of a maker's pride. A perfectly performing Otis installation is Otis' best salesman. That's why we're never satisfied with anything less than peak performance at all times.

OTIS ELEVATOR COMPANY • 260 ELEVENTH AVENUE • NEW YORK 1, N. Y.

the arteries that circulate the at NEW YORK POLYCLINIC"

OFFICES IN 297 CITIES ACROSS THE UNITED STATES AND CANADA

Pagemaster provides instant contact throughout the 43-acre, 83-building plant of Parke, Davis & Co. in Detroit.

Instant paging in 83 buildings . . . with Pagemaster®

You might think it's hard to keep track of a key man in the Detroit plant of Parke, Davis & Co., where 83 buildings spread out over 43 acres.

But with a Pagemaster *Selective Radio Paging System* by Stromberg-Carlson, Management can *instantly* and privately contact any individual equipped with a pocket receiver—no matter where he is, indoors or out.

You, too, may face the problem of reaching key people in a multi-building plant. Or yours may be a one-building operation. *Pagemaster is equally effective in both cases.*

Here's how the system works: your key people are equipped with transistorized pocket-size receivers. An encoder, about adding-machine size, is installed next to your switchboard. A transmitting antenna is conveniently located elsewhere on your premises.

When you want to contact an individual who may be away from his usual location, your switchboard operator sets dials on the encoder and flips a switch. Instantly, that person's receiver—and *only* his—responds with a pleasant tone signal. He simply picks up the nearest telephone and reports. The signal automatically repeats every 20 seconds until he answers.

You can have a Pagemaster system engineered to suit the specific requirements of your operation. Receivers can be added as you need them without additional installation costs. *You can lease a system as well as buy it outright.*

Streamlined pocket receiver weighs only 7 oz.

For complete information, contact the Pagemaster distributor listed, by cities, in the column to the right. Or write to us at 202 Carlson Road.

"There is nothing finer than a Stromberg-Carlson"

STROMBERG-CARLSON

A DIVISION OF GENERAL DYNAMICS CORPORATION

Pagemaster Sales • Rochester 3, N. Y.

Electronic and communication products for home, industry and defense

AUTHORIZED DISTRIBUTORS

Atlanta 3, Georgia
The Lanier Co., 151-55 NW Spring
Baltimore 18, Maryland
John A. Morefield, 3120 St. Paul
Birmingham, Alabama
The Lanier Co., 2129 7th Ave. S.
Boston 15, Massachusetts
DeMambro's, 1095 Commonwealth
Buffalo 10, New York
Regal Electronics, 795 Clinton
Camp Hill, Pennsylvania
John A. Morefield Company
Canton 9, Ohio
George F. Ebel, 3017 NW Cleveland
Sanford, North Carolina
Cmnwlth Assoc., Box 1025
Chattanooga, Tennessee
The Lanier Co., 19 Patten Pkwy.
Chicago 39, Illinois
Boom Electric, 5226 W. Grand
Cincinnati, Ohio
Shaffer Music Co., 1200 Walnut St.
Cleveland, Ohio
J. J. Skinner Co., 25010 Lakeland
Columbus 8, Ohio
Shaffer Music Co., 849 N. High St.
Dallas 31, Texas
Carter Engineering, 6762 Greenville
Dayton 2, Ohio
Copp Radio Labs, 333 W. Monument
Denver 3, Colorado
Empire Radio & TV, 1100 Bwy.
Detroit 7, Michigan
C. A. Nutting, 6353 E. Jefferson
Houston 6, Texas
Audio Center, 1633 Westheimer
Indianapolis, Indiana
Shaffer Music Co., 1327 N. Capitol
Jackson, Mississippi
The Lanier Co., 130 S. President
Jacksonville, Florida
The Lanier Co., 123 W. Beaver
Kansas City 2, Missouri
Engineered Sound & Comm. Co.
18 W. 63rd St.
Knoxville, Tennessee
The Lanier Co., 1800 Grand Ave.
Los Angeles 17, California
Guardian Pacific Co., 6th & Grand
Lubbock, Texas
Radio Paging Service
503 G. Plains Life Bldg.
Memphis, Tennessee
Bluff City Dist. Co., 234 East St.
Miami, Florida
The Lanier Co., 300 NW 12th Ave.
Milwaukee 4, Wisconsin
United Organ Co., 640 W. Va. St.
Minneapolis 3, Minnesota
Stark Radio Supply, 71 S. 12th St.
Nashville, Tennessee
The Lanier Co., 212 6th Ave. S.
Nassau, New York
Hudson Associates
New Orleans 20, Louisiana
E. Emile Rackle, 3855 Airline Hwy.
New York 11, New York
Gross Distributors, 216 W. 14th St.
Oklahoma City, Oklahoma
2-Way Radio, 921 NW 4th
Philadelphia 21, Pennsylvania
J. H. Sparks, Inc., 1618 N. Broad
Pittsburgh, Pennsylvania
Hahn Radio, 700 Penn Ave.
Turtle Creek, Penna.
Portland 11, Oregon
Manchester-Chandler Co.
2915 N. E. Alberta
Richmond 6, California
Watson Communication Systems
10533 San Pablo Ave.
Richmond 19, Virginia
Cottrell Electronics Corp.
408 East Main Street
Rochester, New York
Rochester Radio Supply, 600 E. Main
Salt Lake City 2, Utah
Standard Supply, 225 E. 6th S.
P. O. Box 1047
Seattle 3, Washington
W. D. Lasater Company, 615 No. 35th St.
Spokane 1, Washington
NW Electronics, N. 102 Monroe St.
Springfield 9, Massachusetts
Valley Sound Corp., 958 State Street
St. Louis 13, Missouri
Tesco Telephone Electronic Sound
2612 N. Kings Highway
Syracuse 3, New York
W. G. Brown Sound Equip.
521-527 E. Washington St.
Tampa, Florida
The Lanier Co., 4025 Henderson
Toledo, Ohio
Warren Radio Company, 1002 Adams St.
Turtle Creek, Pennsylvania
Hahn Radio, 700 Penn Ave.
Waco, Texas
Waco Communications, 1213 Clay
Washington 5, D. C.
Tempo Electronics, 1341 L St., NW
EXPORT: Ad. Auriema, Inc.
85 Broad, New York 4
CANADA:
Hackbusch Electronics
23 Primrose Ave., Toronto, Ont.

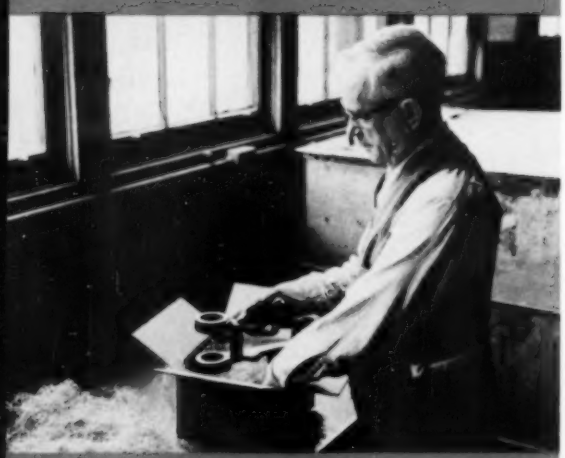
There's no time for laundry downtime!

American saves your time with 9 strategically located parts depots.

You get more from

American

THE AMERICAN LAUNDRY MACHINERY COMPANY



These nearby parts depots mean **fast service** when you need it.

Seattle, Washington
San Francisco, California
Los Angeles, California
Dallas, Texas
Atlanta, Georgia
Chicago, Illinois
Cincinnati, Ohio
Kenilworth, New Jersey
Rochester, New York

Nine depots, each fully stocked with thousands of essential parts, are the backbone of American's extensive nationwide service network. Strategically located throughout the country, these depots are geared to provide fast, emergency service wherever you may be.

In the normal course of operating a laundry, the need for repair parts arises from time to time. This need not be a major problem — that is, if fast, dependable parts delivery is available nearby.

Many times, in response to emergency phone calls, parts are shipped from American depots *within the hour* by the fastest possible means. Our records show that of all the orders received for repair parts, more than 70 per cent are shipped the same day! This kind of fast service in emergencies is another important way you get more from American.

You get more from

American

The American Laundry Machinery Company, Cincinnati 12, Ohio

OM NO.	DESCRIPTION	CHARGE	CREDIT	BALANCE	MEMO	DESCRIPTION	CHARGE
212			75.00-	75.00		CS	
212	ROOM	11.50+9				ROOM	11.50
	DRUG	2.75+2				DRUG	2.75
	XRAY	14.00+1				XRAY	14.00
	EKG	15.50+7		31.25		EKG	15.50
212	DRESSGS	1.85+4				DRESSGS	1.85
	LAB	4.00+9				LAB	4.00
	PHYTHPY	12.00+6				PHYTHPY	12.00
	ROOM	11.50+9		1.90		ROOM	11.50
212	DRUG	2.25+2		.35		DRUG	2.25
212	NUR	6.75+9				NUR	6.75
	DELROOM	15.00+9				DELROOM	15.00
	TRANSFU	18.00+8		40.10		TRANSFU	18.00
212	ROOM	11.50+9		51.60		ROOM	11.50
212			25.00-	26.60		CS	
212	DRESSGS	2.35+4				DRESSGS	2.35
	DRUG	7.50+2				DRUG	7.50
	OXY	10.00+9				OXY	10.00
	TRAY	1.65+3		48.10		TRAY	1.65
212	ROOM	11.50+9		59.60		ROOM	11.50

Provides all service revenue totals at a touch of the motor bar!

If you're partial to the vertical charge distribution plan for patient billing, just look at the Burroughs Sensimatic's ability to make the most of its inherent simplicity and low cost.

A touch of the appropriate key, and the Sensimatic automatically identifies, in word or code, the charge on the form. For final proof and revenue distribution totals, you merely turn the Job Selector Knob and press the motor bar once.

With a Sensimatic, even inexperienced personnel quickly master patient billing. For Sensimatic automatically makes many of the decisions for the operator as it swiftly prepares the statement. And in many cases a duplicate copy of this statement satisfies insurance requirements.

The versatile Sensimatic will also handle your other accounting jobs. A flick of the knob and it switches from job to job quick as a wink, does each job automatically, thoroughly.

See this workhorse of hospital accounting in action. Call our nearest branch for a demonstration. Burroughs Division, Burroughs Corporation, Detroit 32, Michigan.

Burroughs

BURROUGHS SENSIMATIC
Accounting Machines

We'll pay for a
for 6 of

SHOWN: BEEF STEW

OTHERS:

BEANS WITH TOMATO SAUCE
CHILI CON CARNE
MACARONI IN CHEESE SAUCE
PORK & BEANS
SPAGHETTI
BEANS WITH MOLASSES
CHICKEN STEW WITH DUMPLINGS
MACARONI CREOLE
CHICKEN NOODLE DINNER
BEEF GOULASH
SPANISH RICE
CHOP SUEY

2 SIZES OF

HEINZ HOT PLATE LUNCHES

Which fits your operation?

8-oz. Portion Pack in the 13 varieties listed at left. No cooking, simply heat (in three minutes) in Heinz Hot Plate Lunch "Kitchen." Complete portion and cost control.

Heinz Hot Plate Lunch your customers

TRY THIS LABOR-SAVING SHORTCUT AND WATCH THEM GO FOR IT. *THE TEST IS AT HEINZ EXPENSE!*

If you will mail the coupon, we will send you, without cost or obligation, enough Heinz Hot Plate Lunches to serve six customers.

Sell them the food at the price you'd charge if you had paid for it. Then ask them: "How did you like the flavor? What did you think of that for value?"

THEN FIGURE YOUR SAVINGS. We feel sure that your customers *will* approve Heinz Hot Plate Lunches. When you see that they do, figure all the money savings they can bring you:

You can serve these Heinz dishes with practically no work or labor costs. You end the leftover problem. You save cooking fuel. You free your cooking equipment for higher-priced dishes. And you control your costs so you know exactly what you make on every portion!

IT'S NO TROUBLE TO TRY. It won't take you five minutes of work to open, heat and serve these Heinz Hot Plate Lunches to 6 customers. Give them a try, and let the results decide for you. Fill in and mail the coupon for your free Heinz Hot Plate Lunches now.

HEINZ 57 HOT PLATE LUNCHES

MAIL FOR FREE SAMPLES—SERVE 6 CUSTOMERS AND SEE!

You Know It's Good Because It's Heinz

49-oz Chef Size is big enough to virtually eliminate labor, small enough to end leftover problem. Your costs are always under perfect control. Quality? Mail the coupon and see.

H. J. Heinz Co., Hotel and Restaurant Department
Box 28-D7, Pittsburgh 30, Pa.

I'll see how a half dozen of my customers like Heinz Hot Plate Lunches. The variety I want to serve them is

_____
(choose from list on opposite page)

Name_____ Position_____

Affiliation_____

Street_____

City_____ Zone____ State_____

At Booth Memorial Hospital, Flushing, L. I., this Castle Hi-Speed Emergency Sterilizer delivers the goods. One of two such units between operating rooms, this all-Monel autoclave delivers sterilized instruments in minutes.

How Wilmot Castle units sterilize at top speed

Time-saving autoclaves at Booth Memorial are made of Monel alloy and Nickel-clad steel

In emergencies, fast instrument sterilizing can help save lives. And fast bulk sterilizing can ease the burden of heavy workloads.

So at Booth Memorial, quick-acting Wilmot Castle autoclaves are used throughout – in Surgery, in Central Supply and in the examination rooms.

Made of Monel* nickel-copper alloy and Nickel-clad steel, these units are counted on for top speed performance.

3 minute sterilizing

In surgery, for example, Castle cylindrical autoclaves with double-walled Monel chambers work fast. They'll sterilize an instrument inadvertently dropped or omitted from a kit at 270°F. in just 3 minutes! . . . important where speed means everything.

In Central Supply, too, Castle bulk sterilizers with tough, lifetime Nickel-clad chambers rapidly take care of peak requirements with minimum labor and maintenance.

Smooth, solid metals

Monel alloy and Nickel-clad steel go a long way in assuring the quick, trouble-free operation of Castle units. These smooth, solid metals resist corrosion by saline solutions, steam, organic debris and cleansers. Surfaces remain smooth, easy to clean. There's no peeling or warping despite the extremes of temperature encountered daily. Both metals are easily welded, eliminating need for riveted construction and possible leakage.

Any way you look at it, Castle's Monel and Nickel-clad all-welded sterilizers are truly built for a lifetime.

Making plans for modernizing?

For new building write to Wilmot Castle Hospital Planning Service, Rochester, N. Y.

*Registered trademark

The International Nickel Company, Inc.

67 Wall Street INCO New York 5, N. Y.

INCO NICKEL ALLOYS

Bolta Floor®

(SOLID VINYL FLOORING)

rugged, non-porous resists soil and wear

Beautiful, resilient Bolta-Floor is the perfect flooring for busy hospital corridors, reception areas and patient's rooms. It cushions noise from wheeled equipment and footsteps . . . resists scuffs and stains . . . won't crack, chip or shrink. Bolta-Floor remains unharmed by water and detergents . . . keeps its rich lustrous beauty years longer.

GENERAL® PLASTICS
The General Tire & Rubber Company

THE GENERAL TIRE & RUBBER COMPANY
BOLTA-FLOOR DIVISION • AKRON 9, OHIO

SPECIFICATIONS: Bolta-Floor is available in 23 marbleized, 24 "Terrazzo" and 5 solid colors, in standard 9" x 9", or special orders of 6" x 6", 12" x 12", or 18" x 18" tiles in .080" and ⅛" gauges. Solid and marbleized are also offered in ⅛" gauge and in 27", 45" and 54" roll widths for floors, walls and countertops. See Sweet's 13i/Ge.

LIQUI-MED

. . . New Dimension in Therapy Regulators!

Streamlined, efficient function . . . that's the new dimension you get in Liqui-Med Therapy Regulators. Designed expressly for use by hospital personnel, they provide optimum accuracy, virtually eliminate mistakes.

Stainless steel diaphragm. Nylon pointed adjusting screw prevents metallic friction . . . exclusive REGULITE adjusting cap gives error-free settings . . . 4000 lb. H.P. O_2 gauges for extra safety. Write for free literature.

FOR SAFER MORE EFFICIENT ANESTHESIA

EXCLUSIVE! THE

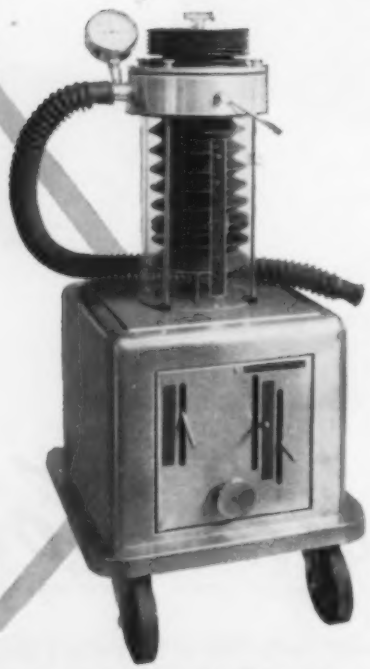
Mörch

SURGICAL RESPIRATOR

Developed by an experienced anesthesiologist who has designed respirators for many years, the Mörch respirator provides the safe, efficient, modern conditions demanded by present-day surgical techniques.

- Reduces the amount of anesthesia needed.
- Relaxes the abdominal wall.
- Provides a quieter surgical field.
- Follows patient's respiration.
- Easy adjustment of rate, pressure and volume.
- Connects to any anesthesia apparatus, or can be used without apparatus.
- Operated by compressed air or oxygen — no electrical components.
- All rubber parts are conductive.

Now exclusively represented by Liquid Carbonic. Write for full particulars.

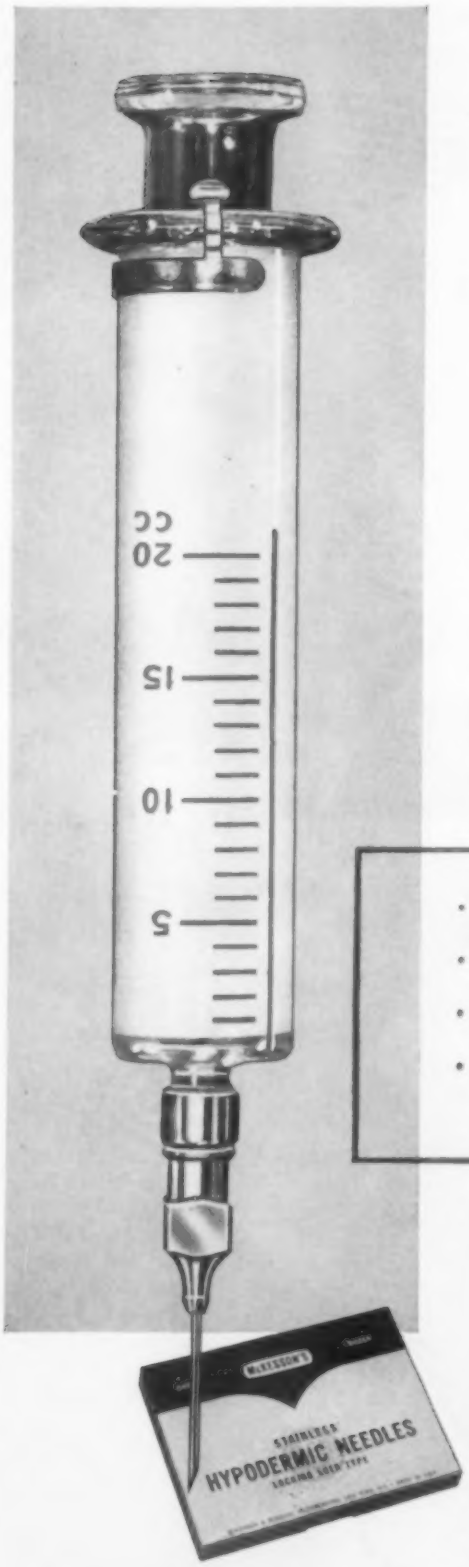


Liqui-Med

LIQUID CARBONIC

DIVISION OF GENERAL DYNAMICS CORPORATION

3100 South Kedzie Avenue, Chicago 23, Illinois



AN INVITATION TO COMPARE
McKESSON & ROBBINS
NEW, COMPLETE LINE OF

HYPODERMIC SYRINGES AND NEEDLES

Compare them, price for price, quality for quality, with any other premium syringes

No matter what hypodermic syringes and needles you are now using, we invite you to compare. Quality for quality—price for price.

Consistent Superior Quality . . . Exacting high inspection standards of raw materials and during production insures surpassing of government specifications at all times.

Special Service! Available locally through 78 McKesson warehouses completely stocked from coast to coast, you have almost instantaneous service in emergencies.

New Savings! . . . On your bookkeeping and delivery costs when you order from one source, with one set of bills, from the nearby local McKesson house now serving you in many other ways.

EXAMINE THESE ADVANCED FEATURES

- Barrel markings and dosage line on plunger are indelibly embedded *into* the glass. Syringes can be autoclaved indefinitely.
- McKesson's hypodermic syringes have all graduations in red for highest visibility.
- Interchangeable plungers fit perfectly into any McKesson syringe of the same size. Replacements may be ordered separately.
- Stainless steel needles: tough, strong and highly corrosion-resistant. Each point is carefully hand-finished and honed. The McKesson needle, which comes with long or short bevel, fits all Luer-tapered syringe tips.

COMPARE! *Now that you have the facts, see for yourself! Arrange today for a trial supply with your local McKesson representative. Or write!*

HOSPITAL DEPARTMENT,
McKesson & Robbins, Inc.
155 E. 44th St.
New York 17, N. Y.

Serving America's Hospitals

McKESSON & ROBBINS


Stop
this
With
this!

Honeywell Round,
world's most popular thermostat.

Nurses aren't trained to control room temperatures

Honeywell bedside thermostats are.

Honeywell bedside thermostats
free busy nurses from chambermaid chores.

Today, when 64% of hospital expenditures are for payroll, one important answer to cost reduction lies in increasing self service by the patient. And Honeywell Bedside Temperature Control allows patients to adjust room temperatures to suit themselves, frees nurses from opening and closing windows, filling hot water bottles, carrying blankets and adjusting convectors and cooling equipment.

In addition, Honeywell Bedside Temperature Control helps speed patients' recovery because it provides a psychological atmosphere of comfort and, in special cases, doctors can prescribe room temperatures ideal for each patient.

Specify Honeywell Bedside Temperature Control for your new hospital or addition. It can also be added to existing rooms without redecorating or tearing out walls. The outer ring of the famous Honeywell Round Thermostat snaps off for easy decorating, too. And the cost is as low as $87.50 per room.

For more information, call your local Honeywell office or write Honeywell, Dept. MH-2-33, 2727 4th Avenue South, Minneapolis 8, Minnesota.

MINNEAPOLIS **Honeywell**

H First in Controls

PHOSPHO-SODA prompt action (FLEET)®

PHOSPHO-SODA satisfactory results (FLEET)®

PHOSPHO-SODA (FLEET)®

Phospho-Soda (Fleet) is recognized as an effective laxative in the treatment of long term constipation or occasional costive distress . . . and as an intestinal cleansing agent prior to examination or surgery. Each 100 cc. contains 48 Gm. Sodium Biphosphate and 16 Gm. Sodium Phosphate.

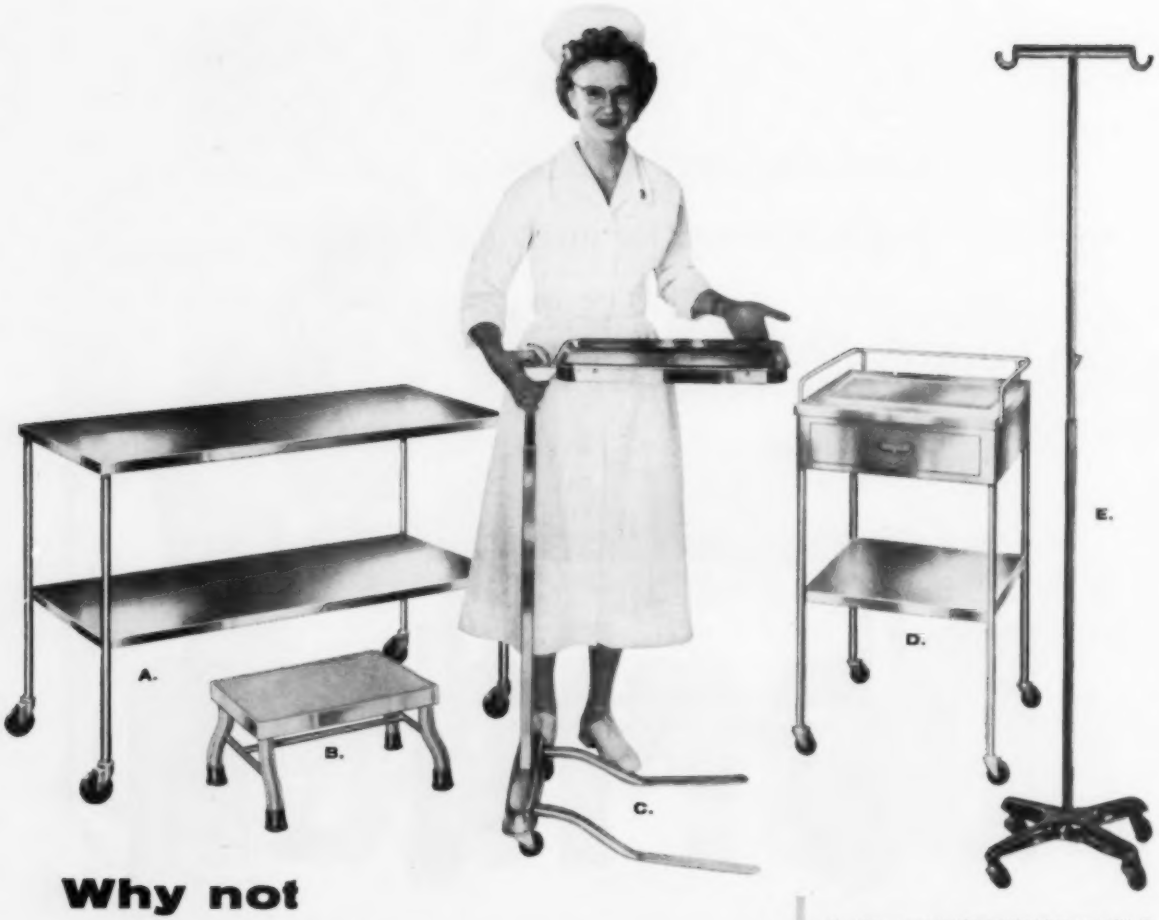
since 1889 Fleet

C. B. FLEET CO., INC.
Lynchburg, Virginia

also makers of

FLEET® ENEMA *Disposable Unit*

OIL RETENTION ENEMA (FLEET)®



Why not the finest when it costs no more?

Stainless steel equipment is truly the epitome of hospital furniture. Now you can afford the finest stainless steel equipment for your hospital...and it costs no more. Blickman offers an entire line unmatched for quality, specially designed for use in every part of the hospital from the nursery to the autopsy room. Designs incorporate the latest advances in technique. Every item reflects Blickman craftsmanship...the result of a lifetime of experience in raising steel fabrication to true art.

All equipment is built of heavy gauge stainless steel and fitted with conductive casters, tips or glides. All items feature Blickman's famous seamless weld construction throughout for maximum sanitation.

For full information regarding stainless steel hospital equipment write to S. Blickman, Inc., 1502 Gregory Avenue, Weehawken, New Jersey.

A. Howard INSTRUMENT TABLE
7830 SS
Seamless all-welded construction and sound-deadening sub-top. On swivel conductive rubber casters. 20" x 36" x 32" high. Other sizes.

B. Winfield FOOT STOOL
7758 SS
Strongly-braced, flared legs assure absolute stability. Top has electrically-conductive rubber tread. 18" x 12" x 8" high. Other sizes available.

C. Manhattan MAYO STAND
7740 SS
Easy, one-hand control, absolute stability. Internal, non-slip device locks tray at any height, automatically. Fits under all operating tables.

D. Ferguson UTILITY TABLE
7850 SS
Durable seamless welded construction. Convenient drawer on swivel conductive rubber casters. 20" x 16" x 32" high.

E. Northern IRRIGATOR STAND
7789 SS
Height adjustment from 72" to 108". Lowered by pressing thumb latch; locks automatically. Heavy base on swivel conductive rubber casters.

Visit Booth #115, **A.O.R.N.** Show Bellevue Stratford Hotel, Phila., Feb. 10, 11, 12, 1958

Blickman-Built Look for this symbol of quality

BLICKMAN
HOSPITAL EQUIPMENT

Perk up patients...and the bright spots in their routine days are often the meals. So serve them on pleasant, appealing Roylprint Paper Place Mats or Roylies Tray Mats... they're light-hearted and cheerful. Colorful paper Roylies or Custom Design Roylprints brighten meals and lighten the staff chores. What's more, Roylprints assure patients of complete sanitation and cleanliness...patients are pleased with the fresh mat for each serving. Roylprints are extra strong, help deaden the noise of chinaware clatter, fit trays perfectly and come in a wide selection of happy colors (one to match your interior design). Or if you wish, you can order Roylprints specially printed with your name and design. Mail the coupon today for more information and samples—no obligation, of course.

Roylprints

Stock and Custom Design
Printed Paper Place Mats

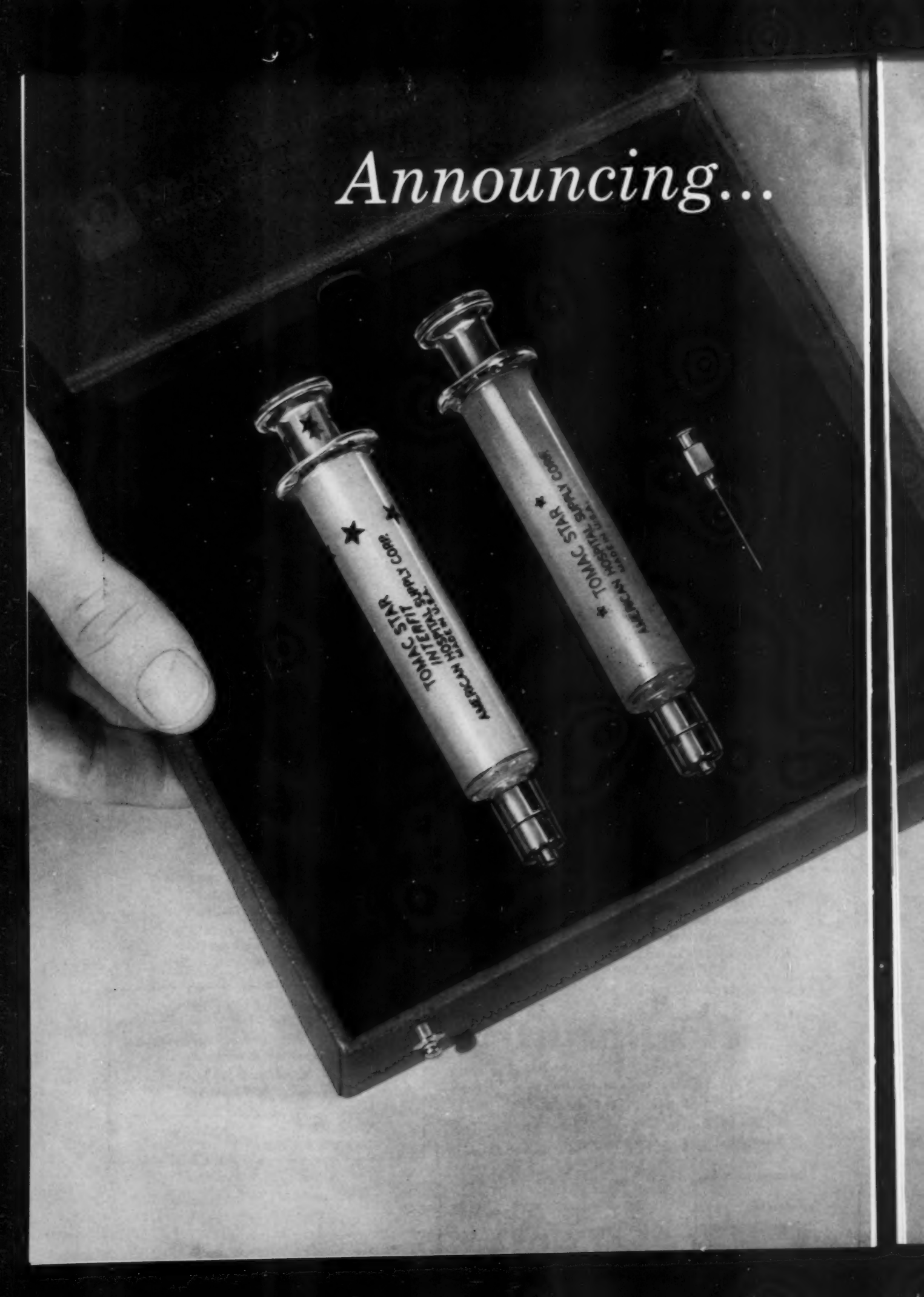
Royal Lace Paper Works, Brooklyn 1, N. Y. (Division of Eastern Corporation)

Royal Lace Paper Works, Dep't. MH-2
99 Gold Street, Brooklyn 1, N.Y.
Please send information on Roylprints and Roylies Place Mats—at no obligation to us.

Name_____

Address_____

City_____ Zone____ State_____


Announcing...
TOMAC STAR
AMERICAN HOSPITAL SUPPLY CORP.
TOMAC STAR
AMERICAN HOSPITAL SUPPLY CORP.

...a new standard of finest precision, greatest durability

American's TOMAC STAR

SYRINGES and NEEDLES

Only **TOMAC STAR** Syringes have all these features:

- **Electronic Size Control**—Perfect fit every time.
- **Easy, Fast Sorting**—All-around markings show ALL THE TIME.
- **"Tuffenized" Glass**—Processed for highest resistance to breakage.
- **Both Barrel and Plunger Precision Ground**—Longer life.
- **Lifetime Markings**—Bold and clear, right in the glass.
- **No-Trap Washer**—Patented design ends fluid entrapment in metal and lok tips.
- **Highest Back Pressure Rating**—Government tests prove it.
- **Choice of Glass, Metal or Lok Tips**—All common sizes.

Only **TOMAC STAR** Needles offer all these features:

- **New, Larger Hub**—Surer, faster, grip when attaching.
- **Every Needle Tested**—Never a burr, never a dull point.
- **Every Cannula Stylette-Tested**—Assures positive fluid flow every time.
- **Chrome-plated Brass Hub**—Rugged, easily maintained.

TOMAC STAR Syringes and Needles provide one more example of American's constant and sucessful effort to bring the very finest equipment and supplies to you. Ask your American Representative to show you these outstanding new products.

Tomac

American Hospital Supply *corporation*

General Offices: Evanston, Illinois New York • Chicago • Kansas City • Dallas
Minneapolis • Atlanta • Washington • Los Angeles • San Francisco • Columbus

SMALL HOSPITAL QUESTIONS

Employe Health Policies

Question: Should the board or the medical staff or the administrator have the authority to determine health policies for hospital employes—such as preemployment physical examinations, periodic checkups, and immunization programs?—A. M., Mich.

ANSWER: The board of trustees should determine what the hospital's policy is going to be, with advice of the appropriate committee of the medical staff, and then the medical staff should be given responsibility for carrying out the established policies. In connection with a decision such as whether or not to immunize against Asian influenza, for example, certainly the board should take the advice of the medical staff and not try to enforce its own opinion on a professional problem against the best advice of physicians who have been given this specific responsibility.

When to Use Bed Rails

Question: Following a recent safety inspection, our liability insurance carrier warned that we were not using bed rails in some cases where they were indicated, especially with elderly patients. Are there positive indications for the use of bed rails?—H.O.N., Ga.

ANSWER: Certainly bed rails should be installed in every instance where disorientation occurs, or where the patient is likely to move about or "thrash" in bed, or where drugs are used that may produce loss of vision, muscular control and alertness; all these indications are more positive, of course, in the case of elderly patients. However, it should be emphasized that while falls from bed constitute half or more of all hospital accidents involving patients, the installation of bed rails alone is not a guarantee of safety, as the disturbed or disoriented patient may fall while trying to climb over the bed rail to get out of bed. In fact, in one series of hospital accidents reported not long ago, there were more falls involving patients with bed rails than without them!

For the disoriented or the disturbed patient, there is no substitute for close nursing supervision. Many falls occur because nursing supervision has been lax and the patient is trying to get out of bed to go to the bathroom; others are attributed to highly polished floors, misplaced stools, liquids spilled on floors, and other causes indicating careless nursing or housekeeping supervision.

Don't Mix Business and Board

Question: Should members of the hospital board be permitted to enter into any type of business relationship with the hospital—as, for example, in the capacity of a supplier?—C. T., Tenn.

ANSWER: This question was referred to a consultant who is president of a hospital board of trustees in a small community, who has replied as follows:

I would not be too happy about this type of relationship, but certainly it is unavoidable in some communities. In a small town where there is only one, privately owned, water company supplying water to the hospital, for example, the board might have no choice. Again, the restriction should not apply to a lawyer on the board of trustees, because in many instances he is appointed specifically because he is the hospital's lawyer and offers his advice on legal problems as they arise. In some cases, trustees who happen to be lawyers may prefer that someone else should represent the hospital legally. As a general rule, it is definitely undesirable for trustees to have business relationships with the hospital.

Discounts Diminishing

Question: Is it customary for members of a hospital staff (medical staff) to be given discounted rates for hospital services for themselves and their families?—G. W. H., Ga.

ANSWER: The practice is still widespread, but not universally the case as it was a few years ago. Many hospitals have used the advent of Blue Cross and other forms of hospitalization insurance to eliminate discounts for staff members who have been enrolled in these plans. Hospital administrators who have eliminated discounts report that the result has been fewer problems with staff members, and less embarrassment about discounted bills. In some instances, discounts are also offered to hospital trustees and members of their families, but this practice, too, is gradually being eliminated.

Most trustees of hospitals like to feel they are serving the community through membership on the hospital board, and would much prefer to receive no material reward whatsoever, even in the form of discounted hospital bills. Finally, it should be remembered that the discounted bill must be paid for by someone; certainly people who are paying hospital bills would not like to think they are being charged a little more than was absolutely necessary just so that the hospital could discount the bills of doctors and trustees who can well afford to pay for their own hospital care.

Are Rates Too High?

Question: We have had to raise our rates several times in the past few years to keep up with rising costs. I feel sure our increases are in line with those that have been necessary in other hospitals, but some of the doctors in our community, especially, have complained that our increased rates are excessive. Can you tell us what has been the experience of other hospitals in regard to their rates?—L.R., Wash.

ANSWER: Of course, rate increases depend to some extent on the economy of the individual community, and it would be difficult to analyze your cost and price structure properly without knowing a great deal about the hospital and community situation.

Among hospitals generally, however, the Bureau of Labor Statistics price index indicates that rates have increased an average of 8.5 per cent per year since 1941. If your increases are within or close to this average, you can assure the doctors in your community that you are not "out of line," as has been charged.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Let these labels be your guide to the wholesome "All-Family Drink"

For easy recognition every bottle of 7-Up displays its name on the front.

But we're striving for something more than simple identification. We want you to *know* exactly what goes into this refreshing soft drink. How pure it is. How wholesome.

That's why each 7-Up container carries a "second" label on the back—an ingredients listing.

Seven-Up is just what this label says it is . . . quality which you may unhesitatingly recommend.

Quality...on the label ...in the bottle

SEVEN-UP CONTAINS:

CARBONATED WATER. Uniformly treated to be colorless, odorless, tasteless. The carbonation stimulates digestion . . . makes drinking 7-Up *more* than a pleasure.

SUGAR. Meets standards far more rigid than those for table sugar. Tested and retested in 7-Up laboratories to insure absolute quality.

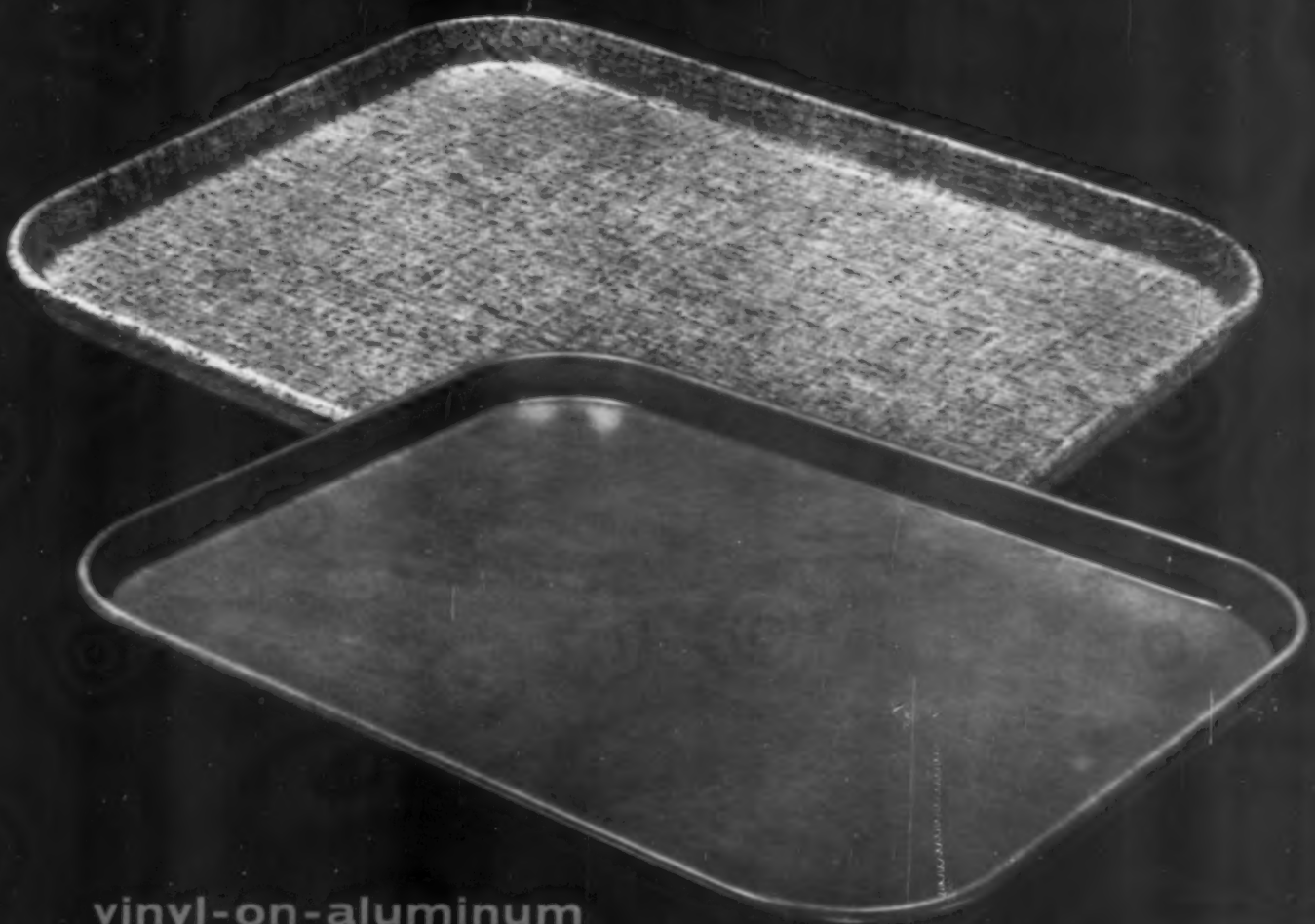
CITRIC ACID. The natural acid present in citrus fruits. In 7-Up it complements the flavor essence extracted from fresh lemons and limes.

SODIUM CITRATE. A small amount of this valuable citrate helps develop the superb flavor of 7-Up.

FLAVOR DERIVED FROM LEMON AND LIME OILS. *Natural* oils pressed from fresh lemons and limes, and super-refined to derive the very essence of their pure, natural flavors.

Nothing does it like Seven-Up!

NEW! STRONGER! SMARTER!



vinyl-on-aluminum

Beauti-trays by WEAR·EVER

Now, a revolutionary new process bonds beautiful, heavyweight vinyl to strong, long-lasting Wear-Ever Aluminum—to bring you these important advantages . . .

- **Permanent Finishes**—will not fade or discolor, even in dishwashers.
- **Extra Strength**—made to *last*, will not warp, crack, chip or peel.
- **Stain Resistant**—gives amazing resistance to acids, alcohol, juices.
- **Scuffproof**—shrugs off hardest usage. *Keeps* its good looks.
- **Quiet**—vinyl surface does away with noise and clatter, pleases customers.
- **Easy to Handle**—perfectly balanced. Light, yet stronger than ordinary trays.

—Complete range of sizes to meet every serving need

Hospital Size: 20½ x 15¼ | Cafeteria Size: 17 13/16 x 13 15/16 | School Size: 16⅜ x 12 | Bus Boy Size: 27⅞ x 22¾ | Waitress Size: 25½ x 20¾

(all sizes in choice of grey linen or suntan top surface, with smart, contrasting bottom)

Beauti-Trays by WEAR·EVER

WEAR-EVER ALUMINUM TRADE MARK REG. U.S. PAT. OFF.

At Your Restaurant Equipment Dealer's, or write: THE ALUMINUM COOKING UTENSIL CO., INC., WEAR-EVER BUILDING, NEW KENSINGTON, PA.

THE VAST MAJORITY OF THE NATION'S FINE BUILDINGS ARE SLOAN EQUIPPED

SKIDMORE, OWINGS & MERRILL
architects—engineers

TURNER CONSTRUCTION COMPANY
general contractor

ECONOMY PLUMBING & HEATING CO.
plumbing contractor

WARREN BARR SUPPLY COMPANY
plumbing wholesaler

RICHMOND PLUMBING FIXTURES, DIVISION OF RHEEM MFG. CO.
fixture manufacturer

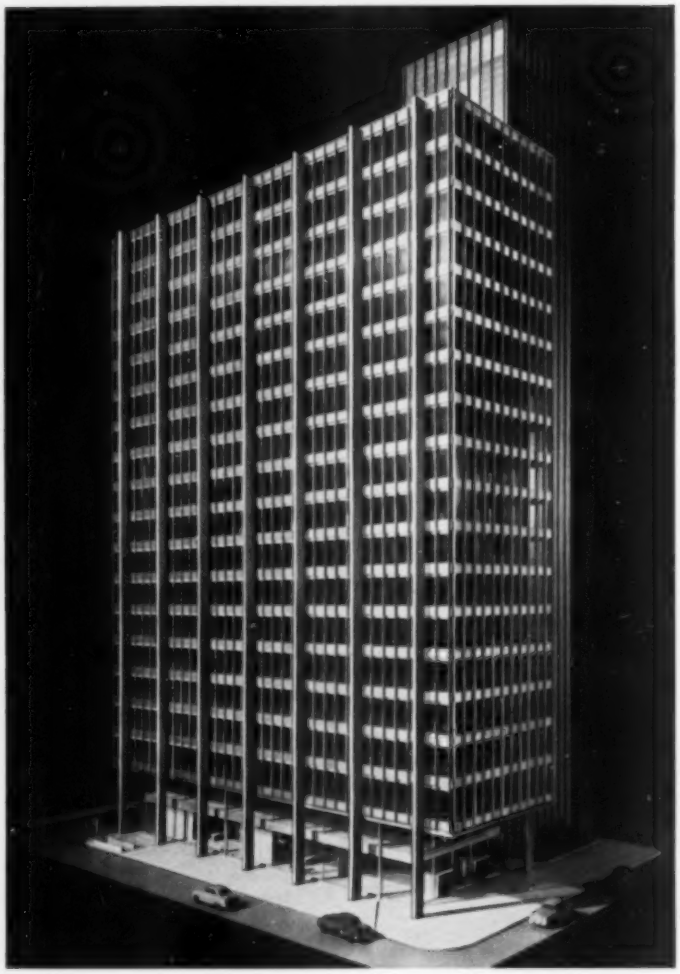
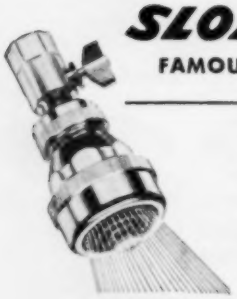


Photo • HEDRICH-BLESSING

SUPERBLY CRAFTED OF STEEL AND GLASS

• The new 19-story INLAND STEEL BUILDING in CHICAGO is a gleaming structure of stainless steel and green-tinted glass above a recessed ground floor—no stores or shops. It is a praiseworthy achievement in planning that provides occupants with many most-wanted features. The entire main block is supported on seven pairs of exterior columns. Each floor is a wide open area, unobstructed by pillars, and may be divided by movable steel partitions which are anchored into metal channels in ceiling grids. An adjoining 25-story windowless steel tower houses elevators, fire stairs, washrooms and other utilities. The cellular steel flooring, topped by lightweight concrete, carries air conditioning to perimeter floor grilles and electrical service and telephone wiring to all sections of the office floor. As are thousands of other expertly planned buildings, this new pace setter is completely equipped with SLOAN *Flush* VALVES.



SLOAN *Flush* VALVES

FAMOUS FOR EFFICIENCY, DURABILITY, ECONOMY

SLOAN VALVE COMPANY • CHICAGO • ILLINOIS

Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

Write for completely descriptive folder

wire from Washington

BUDGET SURPRISES IN HEALTH FIELDS

Congressional committees now are at work attempting to reshape to their liking a budget that, as it came from the White House, was loaded down with surprises in the hospital-health fields—and unpleasant surprises to officials responsible for the federal programs.

It is heavy with increases and new ideas in the fields of science education and defense science.

But the hospital-medical programs are cut, many of them drastically, and the President's budget message makes it clear that the federal government will be doing less and less in these fields in the future, if Mr. Eisenhower and his advisers have their way.

The critical weeks are right now, when House and Senate appropriations committees are going over the budget item by item. In the past Congress has consistently boosted the Eisenhower requests for hospital-medical work, with Rep. John Fogarty (R.-R.I.) and Sen. Lister Hill (D.-Ala.) leading the restoration drives. Whether these two key men will be as successful this year—when the Administration's cuts are deeper than ever and when the country is more interested in security than health—is another matter.

MOST SIGNIFICANT REDUCTIONS

Although reductions appear all up and down the hospital-medical pages in the budget, here are the most significant:

1. **The Hill-Burton hospital** construction program took the most serious lambasting, being knocked down from a total of $121,200,000 for the current year to $75,000,000 for the next fiscal year, the lowest figure since early in the Korean war when virtually all government construction except defense was halted.

2. **In his budget message** the President said flatly that a federal employes health insurance plan would not be recommended this year; because Congress itself isn't looking around for new ways to spend money, it can be assumed that on this at least even the Democrats will be glad to follow the Eisenhower lead.

3. **While the total recommended for the research institutes** is exactly the same as that being spent by them this year, a change in the formula may bring about a 10 per cent cut in money available for outside grants. Congress is being asked to permit an increase from 15 per cent to 25 per cent in the special allowances to help research institutions meet the indirect cost of projects. If this is done, the institutes will give more money to help pay indirect or "overhead" expenses, and have less left for the projects themselves. But hospitals and medical schools would welcome the additional 10 per cent.

4. **Veterans Administration,** according to the budget, should have a slight increase for inpatient hospital care—not any more than enough to match rising costs—but less money for outpatient care and a great deal less—$33,000,000 less—for hospital and domiciliary facilities. More than that, the President promises to send a special message to Congress this year that would point out other ways in which V.A. could be cut back.

5. **The President saw no way** to make immediate cuts in public assistance—a great deal of which goes for medical care—but again he said that this is a field in which the federal government is too deeply involved, and he will recommend laws to let U.S. reduce its contribution.

6. **Vocational education**—under which many practical nurses are trained—would be turned over to the states, under the White House plan, as would the financing of plants for treating waste.

HILL-BURTON

Despite all H.-B. officials could do in prebudget arguments and appeals (see this space in January issue) this is what the final White House recommendation was:

For the entire program during fiscal 1959 (starting next July 1), a total of $75,000,000, in contrast to the current year's $121,200,000.

Of this, only $52,800,000 could be used for the "regular" program, in contrast to $99,000,000 this year.

Furthermore, in the Administration's opinion the Hill-Burton program as it now stands should not be extended by Congress this year, but instead allowed to expire as scheduled on June 30, 1959.

On this the President's budget message says:

"New obligational authority for health activities is being reduced, principally with respect to construction of hospitals.

"This will not materially affect the planned level of obligations, because prior-year appropriations are available and will be used. . . . The authorization legislation for hospital construction grants will expire on June 30, 1959. In view of the progress already made toward meeting community hospital requirements for general beds, the federal program should be modified to meet only the most urgent needs, with emphasis on specialized needs."

Many in the hospital field will disagree with the statement that great progress already has been made in hospital building, and certainly anyone connected with state or national H.-B. work will dispute the claim that an abrupt cutback in funds "will not materially affect the planned level of obligations. . . ."

Technically, the latter claim is accurate. However, the practice is widespread for states to make informal commitments to local sponsors, most of whom will be left hanging in mid-air if the national total is held at $75,000,000.

It is understood the Administration is anxious to drop the general hospital assistance as soon as it conveniently

can, and concentrate a smaller amount of grant money in the categories—nursing homes, rehabilitation facilities, hospitals for the chronically ill and impaired, and diagnostic-treatment centers. In response to the growing interest in the problems of the aged, there is some talk of swinging the emphasis to a facility that would be something between a nursing home and a hospital.

VETERANS ADMINISTRATION

Those who would like to see a substantial increase in Veterans Administration hospitals, staffs or services, find little comfort in what the President says on V.A.:

"Fundamental changes have taken place in our society in the last several decades which require us to reconsider the laws providing veterans benefits and services which now overlap other growing public benefit and welfare programs.

"As I indicated last summer, a message on veterans affairs will be sent to the Congress at an early date. In that message there will be set forth for the consideration of Congress recommendations for specific adjustments and improvements in the compensation, pension and related programs which will enable us to discharge our national responsibilities to veterans with the greatest possible equity to all concerned."

The Administration is anxious to mesh V.A. and other public programs so the pension load and nonservice connected cases could be shifted to social security and public assistance. Whether all of this will be attempted this year is not known.

PUBLIC ASSISTANCE

At present the federal government contributes a high percentage of the money paid out to the needy aged, the blind, the permanently and totally disabled and dependent children, and much of this money goes to pay hospitals and physicians.

In this operation, too, the President wants to find a way out for the U.S. He says:

"These programs are now well established and the individual states have gained experience as to appropriate levels of assistance. In line with my belief that the states should have greater responsibility for programs of this nature, proposals will be sent to the Congress for modernizing the formulas for public assistance with a view to gradually reducing federal participation in its financing."

If this is effected, one of the results could be more aged and disabled patients without resources to meet their full hospital costs, because states are not likely to replace all the money the federal government now is paying toward the medical care of these groups.

Budget Prospects in Brief: Many forces are at work on Congress as it reviews the President's budget—politics (this is an election year), fear that too drastic reduction in U.S. general spending will speed up the recession, a sincere interest in promoting research and medical care. At the least, it is likely that Congress will restore some money to virtually every program that was cut drastically in the President's budget. This applies particularly to Hill-Burton, whose $75,000,000 total is almost certain to go over $100,000,000 before Congress finally passes the bill.

DEPENDENT MEDICAL CARE

Because of some confusion, the army's Office of Dependent Medical Care reminds hospitals and physicians that if a dependent does not have the proper identification card when treated, an explanation must accompany the claim. If not, under the regulations the bill will not be paid.

Other developments in Medicare: The office points out that the government will pay civilian hospitals and physicians for more than 21 days of hospitalization for treatment of acute mental and nervous disorders only under three conditions: (1) if more time is needed for the sponsor to assume responsibility; (2) if retention in the hospital for longer will result in cure or remission, permitting the patient to return home; (3) if the underlying diagnosis for determining length of care can't be made in 21 days.

If the patient prefers semiprivate accommodations to wards, but the hospital has only a ward bed, the hospital must state on the claim form or an attachment the reason semiprivate space was not furnished. However, if the patient is moved to a semiprivate room, the claim may be handled routinely.

Wherever ward care is the normal practice for pediatric cases, the claim also may be put through routinely.

Payment may be made directly to independent (free-lance) nurse anesthetists or physical therapists, provided the service was certified as necessary by the attending physician and the charge is the normal charge.

In its O.D.M.C. Letter No. 3, the office reviews and clarifies many detailed provisions dealing with invoices, adjustments and contracts.

FORAND BILL

According to the House ways and means committee, it will be late March at least before any hearings can be held on the Forand Bill for hospitalization of the aged under social security. Scheduled for action ahead of this bill are a general revision of taxation legislation and extension of the reciprocal trade acts, due to expire June 30.

Thus, although the Forand Bill already is the center of a controversy, there is the growing possibility that it may be held up until too late for extensive hearings this session.

Some committee members already feel that in view of heavy defense-science spending, Congress shouldn't set up a new welfare program that would call for new taxes of about $3 billion a year.

NOTES

Hospitals are well represented in membership of the Health Resources Advisory Committee of the Office of Defense Mobilization. Members are Dr. William E. Walsh of Washington, D.C., assistant professor at Georgetown; Dr. Otis Whitecotton, Oakland, Calif., medical director of the Highland-Alameda County Hospital, and Frances Graff, R.N., of Grand Rapids, Mich., head of the Blodgett Memorial Hospital School of Nursing and Nursing Service. The committee advises on health and medical problems involved in mobilization planning.

A former lieutenant governor of Massachusetts, Sumner G. Whittier, is the new head of Veterans Administration. Mr. Whittier, who was defeated for governor of the state in his last political effort, made a name for himself as chief insurance director for V.A. during the last year. He is a prominent Republican, but it is understood that his showing in the V.A. post rather than political pressure won him the job.

Although the House ways and means committee heard testimony on the Jenkins-Keogh bills, there is not much chance that this legislation will be enacted as part of the omnibus tax bill; it would mean too much loss of revenue. The bill would permit the self-employed to set aside some of their income tax-free for building up retirement funds.

The Modern Hospital
FEBRUARY 1958

LOOKING AROUND

Profession

HOSPITAL administrators who come to Chicago this month to take part in meetings arranged by the American College of Hospital Administrators may feel somewhat elevated to reflect that they are attending a Congress, and not an ordinary convention. For all its heady, international overtones of princes and envoys, however, a Congress is the same thing as a beery convention, and either one is good or bad according to the truth of what is said, and how well it is heeded, and not according to the elegance of its label.

Pondering these matters between lectures at the Congress, the thoughtful administrator may fall to wondering whether or not hospital administration is a true profession, or, more accurately, since it is proper to refer to any calling as a profession, whether it can truly be considered a learned profession.

Of course, there are no exact measurements or standards for determining what is a profession and what isn't. We can't draw an occupation out along its own performance, and if it reaches to an established benchmark call it a profession—and something else if it falls short. Rather, it should be understood that some characteristics of learning and performance are professional and some are not, and one may be more professional than another. An occupation will come close to the center or core of professionalism if it has many professional characteristics and has them to a high degree. To the extent that it lacks professional attributes or has them only faintly, an occupation lies away from the professional center.

The characteristics of a learned profession are well known and have been discussed by scholars and philosophers since the time of Socrates, who made a career out of demonstrating that the professional men of his day didn't know as much as they thought they did—a proposition that has had considerable merit ever since. Certainly the most distinguishing characteristic of a profession is that it must have a specialized body of knowledge or specialized technic that is known by its members and not by others. Moreover, the body of knowledge in a true profession must be intellectual in nature; there is a body of knowledge to be mastered by the tool-and-die-maker, but die-making is not therefore a learned profession.

Egyptian surgeons had the manual skill required to cut into the urinary bladder and remove stones as long ago as 3000 B.C., but surgery did not emerge as a true profession until the Eighteenth Century, when William and John Hunter subordinated surgical skill to anatomic and diagnostic knowledge and careful judgment—the intellectual elements of the surgical body of knowledge. "He helped to make us gentlemen," a Nineteenth Century surgeon-historian said of John Hunter, hinting at another characteristic of the learned professions—learning, or culture, which was linked with social standing in the Eighteenth and Nineteenth centuries and is still no handicap to the professional man, although there are some today, certainly, who seem to get along very well with only a limited supply.

In the true professions as they have been developed over the years, the body of knowledge or specialized technic must be acquired by a specified method, and the specified method in the professions now is formal training. It was once possible to learn medicine or law by serving an apprenticeship, and, incredible as it may seem, there are some physicians still alive and practicing who qualified under the grandfather's clauses in the last states to pass medical practice acts and never went to medical school. But the only portal of entry into a profession today is professional education. There are no short-cuts, and no side doors or back doors, and, generally speaking, the more extensive the training, the nearer an occupation is to the professional center or core. Neurosurgery and nursing are both professions by most definitions, but nursing, with three years of training after high school, is not nearly as professional as neurosurgery, which requires four years of college, and four years of medical school, and a year or more of internship, and then five years of residency training.

Registration or licensure by the state is thought by some to be characteristic of a profession, and it is a fact that an occupation may be considered to have acquired a certain amount of status when the state finds it necessary to certify qualifications and raise some barriers to protect the public against quacks or impostors, but licensure is not a reliable index of the degree of professionalism, or we should have to rank beauty operators and chiropractors, who are licensed, ahead of nuclear physicists, who are not.

Much more reliable as a determinant of professional stature are the barriers that are raised by the members of a calling themselves to qualify new members, admit members to professional societies, and, most importantly, to disqualify and oust those who are inadequately prepared or reveal themselves as otherwise unsuitable. A true profession has ethical as well as intellectual standards and will reject candidates as readily on one ground as the other. Moreover, the content of the code of ethics is significant; in a true profession, the code

is clearly devised to protect the interest of the public and the honor of the profession, and not the pocketbooks of its members.

In a profession, in fact, all pocketbook considerations are subordinated to an ideal of public service. This characteristic was described many years ago by the British economist and philosopher Richard Tawney, who said that the distinguishing thing about a profession is that while men may enter it to earn a livelihood, the measure of their success is the service which they render to mankind. The same concept is basic in the Principles of Medical Ethics of the American Medical Association, which were formulated more than one hundred years ago and have been changed many times but have never lost sight of the first principle, which now reads: "The principal objective of the medical profession is to render service to humanity."

It is an odd circumstance that some physicians who presumably subscribe to this principle have suggested that the method of remuneration is a measure of professionalism, and that it is more professional to be paid directly by the recipient of service than indirectly by one who is not a recipient. Like licensure, however, this is plainly a false standard which would make the village plumber, a fee-for-service man, more professional than the teacher or hospital administrator, who get salaries.

Using all the characteristics of the professions that have been mentioned here, it is possible for one to judge how nearly hospital administration comes to the professional core, compared to other callings. Certainly hospital administration has its own body of knowledge, and it is properly intellectual, but it is neither as extensive nor as definitive today as the specialized disciplines of medicine, or law, or theology—or even nursing, pharmacy or dietetics among the intrahospital professions. The fact is that hospital administration borrows its body of knowledge from other fields, taking a little that lies in medicine's jurisdiction, and some of psychology and the other behavioral sciences, and some accounting, and some law, and some of public administration or government. The borrowings do not add up as yet to a definitive body of knowledge, but they are taking on consistency from year to year and from university to university and already promise a time when we can mark off a discrete area of knowledge to be called by this name and considered truly professional.

There are some who dispute the whole concept of administration as a profession and contend that the nature of the administrator's task is such that he must always remain outside—and some say above—the professions whose members or practitioners he is expected to coordinate. There is abundant evidence, however, that administration itself can be considered a separate, professional discipline. As long ago as 1806, in fact, the task of administrators in Britain's East India Company became so complex and required so much specialized knowledge that a four-year college was established at Haileybury, in England, to train young men for positions as clerks with the company, and for years this was the only way men could qualify for such appointments. Haileybury has its equivalents today in the many schools of public administration, and hospital administration, in our universities.

Formal training is more and more surely the portal of entry to hospital administration, but here, again, it is some distance still from the center, and the short-cuts and side doors are still open, though not so wide as they were a few years ago. The training and other requirements for membership and fellowship in the American College of Hospital Administrators have certainly been effective steps toward the professional center.

Regulation by the state is almost entirely lacking in hospital administration, but, as we have seen, this is a poor standard and not to be considered a serious lack. Hospital administration has its code of ethics, which has just recently been taken off the shelf, dusted and polished a bit, and put back. There is nothing the matter with the code, particularly, and it is properly oriented to protect hospital patients rather than administrators—but there is no mechanism for its enforcement, nor is any contemplated, and so it is not possible to score this as a credit toward professionalism until it has been demonstrated that an administrator who is plainly unethical can be thrown out of his profession and his professional society—and, to be sure, out of his job.

The most difficult standard of all to evaluate is idealism, and, with the possible exception of the body of specialized knowledge, idealism is unquestionably the most important standard of all in judging whether an occupation is a true profession. Inevitably, it is easier to detect the lack of idealism than its presence. The administrator who is content to balance the books and let the nursing service go hang is clearly lacking in idealism and is therefore unprofessional; and so is the administrator who hops from job to job up the salary ladder, leaving behind him unfinished business without regard for the effect on hospital patients and hospital communities; and so is the administrator who lets accreditation slide because he doesn't want any trouble with the staff; and so is the administrator who considers that his responsibility stops at the threshold of the hospital building. But for every hospital administrator who thus lacks the idealism that is characteristic of the true professions, there are many more for whom service to patients is always the first consideration, and who have looked the other way when attractive job offers came along because there was still work to do where they were, and who have worked diligently to get their hospitals accredited, sometimes facing formidable opposition, and who have made big plans to add new functions to the hospital's responsibilities in the community.

Even with its advancing body of knowledge, and its firm strides along the road toward formal training as the only portal of entry, and its increasingly professional societies, and its code of ethics that may some day have teeth, hospital administration seems likely always to remain farther away from the professional center than medicine and law and theology, and even teaching, in all other respects, but in its idealism it is already close to the center. The important thing, however, is not just that idealism is considered professional; the important thing is that idealism in hospital administration helps improve the human condition. As long as hospital administrators hold fast to their idealism and reject graspers and trimmers, it doesn't make much difference whether hospital administration is considered a true profession or not, or whether its annual assemblies are named congresses, conventions or circuses. It will be an honorable and important calling whose practitioners will have and deserve the respect of our society.

Hospital Income Will Come From Everybody

Well people, not the sick, will be increasingly the source of hospital support, through insurance, unions, Blue Cross or the government. Therefore, the author warns, hospitals must treat the well people who are their ultimate source of support as partners so they will understand the problems and support hospitals cooperatively rather than through the government.

MICHAEL M. DAVIS

THIS is a hunting expedition, not a prophecy. It is a hunt for money. Where is the money to meet the steadily and inevitably rising costs of hospitals? How are hospitals to get enough of it to meet their necessities?

Suppose we followed the trail of hospital money back for 75 or 100 years. Then the money of the voluntary general hospitals was mostly obtained by the judicious stimulation of the charitable impulses of the well-to-do.

By the turn of the century, hospitals were in process of transformation from hostels for sick poor to centers of good medical service utilized by well-to-do and middle-income families as well as by the poor. Gradually it followed that the voluntary hospitals obtained most of their money, *i.e.* current income, from their patients.

Before methods of hunting and finding money from patients had been stabilized or adapted to a period of swift rise in hospital costs, a second major change swept upon the hospital field. Through health insurance and through the larger use of local, state and national tax funds, more and more hospital money has come from well people instead of sick people. Well people do not pay for hospital care by the piece, as the care is delivered to them; they pay for it, in whole or in part, for themselves or for designated other persons, by the month or the year. Nongovernmental general hospitals receive, on the average, nearly half of their total income from insured patients. In many such hospitals the proportion from insurance is two-thirds or more.

Money from well people cannot be hunted on the same trail or with the same weapons as money from sick people who are in a hospital. When the trail of well people's money is pursued to the pocketbook, the psychology that opens that pocketbook is quite different. To understand and utilize that psychology will be the key to the successful financing of hospitals in 1975. Sooner, with many hospitals.

A crucial economic fact stands like a guidepost on the trail toward the future. The average cost per day in the short-term hospitals is now about the same as the average cost of short-term hospital care per year per capita of the whole population. In other words, what a sick man would pay you for one day's hospital care is about the same as what a well man would pay for a whole year's assurance of care.

As more and more Americans get to understand this fact, prepayment by the well instead of piecework payment by the sick will extend more and more widely. I should be surprised if the hospital administrators of 1975 do not take as much for granted that 90 per cent of their current income will be from well people as the administrators of 1925 took for granted 90 per cent from their sick people.

One way to get to 90 per cent prepayment is through health insurance, motivated by popular demand operating through unions, employers, other organized groups, and individuals. Another way to get it, by or for some people, is through their votes as citizens of local, state and federal governments, which will determine the policies and appropriations of taxes to pay for hospitalization. The insurance road and the tax road are alternatives towards fulfilling popular demand for universal—or almost universal—payment by well people, instead of piecework payment by sick people. During the last 25 years we have been moving on both roads rapidly.

I share with most hospital people the hope that we shall move forward on the insurance road as fast and as fully as possible, pursuing the tax road where necessary for certain groups of diseases or certain groups of people. The amount and rate of our progress will depend upon the courage and foresight with which the hunt for money on the insurance road

Forecasting trends in hospital financing is an old custom for Michael M. Davis, whose latest book, "Medical Care for Tomorrow," was published by Harper's three years ago. For many years, Dr. Davis observed and commented on the flow of events in hospital administration, medical practice, and medical and hospital economics as secretary of the Committee for the Nation's Health. He has been a consultant and adviser to hospitals, clinics and other groups interested in community health, and for several years served as director of medical services for the Julius Rosenwald Fund in Chicago.

is pursued by those who need the money.

In that hunt, hospital administrators, trustees and physicians need to ponder seriously the pocketbook psychology of well people, as contrasted with the sick.

Hospital patients are sick and anxious people. They or their families function as individual units. Typically, they are not in a psychological or an economic position to be bargainers about rates and charges at the time of their admission to a hospital.

Well people have not the pains and anxieties of sickness to contend with. They are in a position to make up their minds coolly about how much of their money they will devote to prepayment of sickness costs. They can balance this choice with the hundred other choices they must make to spend their income.

The dramatic and well publicized

"THE PUBLIC DOES NOT PAY AS MUCH AS IT SHOULD FOR ITS CARE,"

THE main trouble is that we're in the business of selling the public something it doesn't want—at the very time when it particularly doesn't want it. It's also a public that demands champagne care at beer prices."

Thus, Mark Berke, administrator of San Francisco's Mount Zion Hospital, in a somewhat plaintive plea that must at times have been echoed in one form or another by every hospital official in America.

The occasion for Mr. Berke's words was a recent all-day public meeting, sponsored by the San Francisco Hospital Conference, and possibly unique in its conception and in the frankness of the opinions expressed.

The affair, heavily attended by representatives of nearly every civic group in the city, as well as by many interested individuals, was presided over by Sister Mary Philippa, president of the conference and administrator of St. Mary's Hospital.

There were informal and informative talks by Dr. Kenneth B. Babcock, executive director of the Joint Commission on Accreditation of Hospitals; Sam Kagel, a noted liberal labor lawyer; Louis Lundborg, vice president of the Bank of America and chairman of the San Francisco Committee on Hospitals and Health Facilities, and Dr. Lester Breslow, chief of the California Department of Public Health's bureau of chronic diseases.

But the highlight of the day so far as the audience was concerned was a no-punches-pulled panel discussion of hospital costs, moderated by Edmund G. Brown, attorney general of California and Democratic candidate for the state's governorship. Singularly missing from the discussion was the defensive attitude toward hospital costs which is so often evident where the profession meets the public. Here was an almost unanimous agreement that actually the public is not paying as much as it should for the service it gets.

Here are some of the things the participants had to say.

Mr. Allen is science writer for the San Francisco *Examiner*.

DR. JOHN W. CLINE

"The hospital must train young physicians and nurses and offer postgraduate work for older men"

Dr. Cline

Dr. John W. Cline, noted surgeon and a recent past president of the American Medical Association:

"I would remind the public of the hospital's responsibilities beyond the care of the sick: as a training ground for young physicians; as a place for older doctors to acquire postgraduate training; as a school for nurses. . . . In terms of value received, hospital costs are low, very low. . . . It cannot be forgotten that wages constitute an average 72 per cent of hospital costs, and yet no one can say that hospital personnel is overpaid. . . . In San Francisco in 1937 the cost per patient day was $9.85, with $5.31 of it going to payroll; in 1947 the total was $20.56, with $13.28 to wages; in 1957 the figures are $39.38 and $25.80. . . ."

MARK BERKE

"Where else can you hire the service hospitals give at so low a rate as $1.87 per hour?"

Mr. Berke

Mark Berke:

"Hospital costs are too low and can go nowhere but up. . . . To those who complain about hospital costs I would say this: A patient gets 16 hours a day full-time service from a group of the finest and most skilled personnel in the world, plus the backstop of expensive modern diagnostic and therapeutic machines and laboratories. For another eight hours, while the patient ought to be sleeping if he isn't, it would be fair to say that at least half that service is still available to him, on call for the press of a button. Call this eight hours four full-time hours. This makes 20 hours a day. Divide that 20 into a daily average cost per patient of $37.50. It comes to $1.87 an hour. Where else in the world, where else in what sort of industry can you hire that sort of service at so low a rate as $1.87 an hour? . . . It remains a tribute to hospitals and to the people who run them and work for them that costs are as low as they are. . . . You must remember that it's the doctors who prescribe hospital care, not the hospital people. . . . The only chance I see to cut costs is so to change health insurance policies that they place a premium on keeping a patient out of the hospital, not in. . . ."

ARNOLD BROWN

"The answer lies with the patient and the doctor who connive in the misuse of hospital insurance"

Arnold Brown, third vice president and resident manager of the Metropolitan Life Insurance Company:

"We need the help of all of you in providing the actuarial and logical foundation for proper and foolproof health insurance. We think we're working toward the ideal policy. . . . Mostly we hear the same objections that most of you have voiced: It lies in the patient who says, 'Doc, why don't you put me in the hospital and give me the works; after all I've got insurance,' and the doctor who connives in this kind of misuse of insurance."

Two exchanges brightened the informal question and answer period that followed the panel presentations.

In the first, Attorney General Brown, whose leanings are somewhat left of center, asked Dr. Cline, with hardly hidden relish:

"Would you have any objection, as a possible solution to this problem of costs, to statewide compulsory hospital insurance?"

There wasn't anyone in the audience

advances in the powers of medicine for human benefit—especially during the last dozen years—have brought Americans to appraise the values of hospitalization and other forms of medical care more highly than ever before. That means an increase in their demand for it, but its rising costs have also impelled people to look at medical and hospital service more critically. Well people are in a position to be critical.

Well people contrast with sick people in another important way. Sick people act as individuals, but well persons act largely through organizations or organized groups to which they belong. Among such organizations are those of employers and other businessmen, unions, farmers' associations, churches, clubs, social, professional, civic and political bodies, and last, but far from least, the local, state and national governments. Group

PANELISTS CONTEND AT SESSION ON HOSPITAL COSTS

JOHN FRENCH ALLEN

who failed to predict the answer, and to laugh genially when it came with crisp certainty:

"I can answer that unequivocally, Mr. Brown. I would strongly object." And he grinned at the laughter.

The other exchange also involved Dr. Cline. Mark Berke suggested that —with all other avenues of economy apparently closed to them—hospital administrators and doctors work toward more efficient internal operation. For instance, he suggested, it does seem highly uneconomic to keep operating rooms and their expensive personnel available for an entire shift "when every surgeon demands to operate at 8 in the morning," and the surgery lies idle for most of the remaining time. Couldn't some surgeons operate in mid-morning or in the afternoon? Mr. Berke asked. Doctor Cline rose to this challenge too:

"We've got to remember that for the hospital staff and for the surgeon an operation is part of the day's work. For the patient it is one of the great physical and emotional crises of his life. We bring him in the night before, shave him, keeping him from eating, dose him with sleeping pills. He awakes the next morning anxious to have the business over and done with. To keep him waiting for hours would not only be mentally cruel, but would tend to dehydrate him and otherwise lower his physical stamina.

"Besides," he added, "I'm like those other surgeons Mr. Berke talks about . . ." (this with a grin) ". . . I like to operate at 8 o'clock. And, seriously, of course, there's something to be said for this: I'm fresher and better able to operate first thing in the morning. No, I'm afraid Mr. Berke will have to look elsewhere for his internal economies."

Attorney Kagel and Banker Lundborg spoke on purely local hospital problems, with both noting the need for a shift in facilities: San Francisco has whole wards designed for tuberculosis patients lying idle, while its facilities for the elderly chronic ill are bursting at the seams.

RICHARD LIEBES

"More workers are employed by American hospitals than are employed in the automobile industry"

Mr. Liebes

Richard Liebes, the brilliant young research director for a number of San Francisco labor unions:

"We of labor have a dual interest in hospitals: in the workers who staff them, and in seeing that good care is provided for all our workers under decent and reasonable health insurance plans. . . . More than 1,300,000 workers are employed by American hospitals, a larger group than the 900,000 employed in the automobile industry, and larger than the 1,100,000 working for the railroads. Many people forget this fact. On the other hand, the large bulk of patients using hospital facilities are working people and their families. . . . We freely grant that wage increases have added to hospital costs and that such wages are better than they used to be. But they are still niggardly compared with going wages in other similar industries. Registered nurses—with all their skills —still make less than laborers. . . . In San Francisco the average hospital porter gets $57 a week (more than he does in most sections); yet in San Francisco the rate for similar work in other industries is $92 a week."

MARIAN ALFORD, R.N.

"Vocational nurses must continue to take over more and more of the jobs that merely waste an R.N.'s time"

Marian Alford, R.N., executive director of the California State Nurses Association:

"Hospital costs cannot be solved by machines or lower wages. . . . Part of the answer lies in the more economical use of registered nurses, a better utilization of their skills. . . . Just as registered nurses over the years have taken over more and more of the responsibilities that once were the doctor's alone, so vocational nurses must continue to take over more and more of those jobs which merely waste a registered nurse's time. . . ."

Dr. Breslow, an outstanding public health physician and noted for the sort of forthright opinion not usually expected from public hired hands, closed the meeting with a strong plea for reintegration of all institutional services for the sick. Some excerpts:

"Hospitals originated as places for the care of the feeble and infirm. Over the centuries they have developed into modern 'general hospitals.' Recently they have become known as 'acute general hospitals.' More properly perhaps these institutions should now be called 'acute hospitals' inasmuch as they have almost lost through neglect their function as places for the general care of the sick. Instead they have become converted into places for the diagnosis of illness and treatment of its acute phases, and childbirth—the so-called 'doctor's workshop.'

"Meanwhile society has developed a wide array of other institutions for the care of the sick: mental hospitals, tuberculosis sanatoriums, custodial facilities for chronic illnesses. This fragmentation of institutional services for the care of the sick arose largely on the basis of expediency; it is not a rational plan.

"The time is now arriving for a reintegration of all institutional services to the sick, for the development of a truly general hospital. This will be a place for the patient irrespective of whether his disease is of the body or the mind . . . for chronic and infectious diseases alike . . . for the alcoholic and the mental case.

"What more important policy faces present-day hospital leaders than reversing the long-time trend toward fragmentation of hospital services and starting on the path toward integration of services for the sick in a real general hospital."

action fortifies the individual and enhances bargaining power. Hospital people must expect that in future they will have to deal with organizations of well people as the source of most of their money for current expenses.

Traditionally, the charges for physicians' and hospitals' services have been set unilaterally by those supplying the service—a situation naturally following when the provider of service obtains income from a series of sick individuals. After a hospital bill has been received, the patient or his family may complain or protest and seek a downward adjustment. Such *post hoc* procedures occur in only a fraction of cases and are not an effective way in which the user of hospital service can deal with hospital charges.

Gradually, organized groups representing well persons who prepay hospitalization will become active agents in determining the health benefits they will get and the amounts they will pay for them. They will take initiative in using their economic bargaining power, or their political power, or both, in dealing with those who supply the benefits.

BARGAIN THROUGH BLUE CROSS

Have you followed the beginnings of this process in relation to Blue Shield in California, where collective bargaining between unions and doctors has been under way in some places? Have you considered the significance of the Eisenhower Administration's big addition to "socialized medicine" in the Medicare program? In a large part of this country, hospitals bargain, through their surrogate the Blue Cross, about the rates to be paid out of federal taxes for the care of dependents of servicemen. On the other side of the bargaining table are representatives of the people —the taxpayers—from whose pocketbooks the money comes.

What will happen about the financing of hospitalization and nursing home care for the aged? By 1975, perhaps much sooner, the national government, by itself or in partnership with the states, may have made the financing of care for the aged a public responsibility, through the social security method or otherwise. How will the rates to be paid nongovernmental hospitals for this care be determined? Not unilaterally by the hospitals, or by Blue Cross, we may be sure.

The moment we identify the chief source of hospital finance with well people, we should begin to change our point of view in hunting our money. We must, for example, take a fresh look at the tradition that professional persons and institutions fix their rates of compensation by unilateral action. If I read the signs of the times correctly, that tradition will not be working much in 1975.

Now, what can administrators do today to prepare for easier and fuller financing of their hospitals?

1. Keep in mind that you have an incentive to finance hospitals by well people instead of by sick people. There is more money in the pocketbooks of the well, and it is easier to pay on a budgeted basis than to pay, often unexpectedly, piecework rates for services rendered. Payment by the well also abolishes most collection costs.

2. Remember, however, that the money of well people cannot be demanded. It has to be hunted.

3. Your selling base must shift. You will no longer be selling service at per diem or piecework rates. You will be selling an annual assurance of service. Which will be easier to sell? An assurance of hospital care, whenever necessary, for $30 a year? Or hospital care, when necessary, for $30 a day?

4. Your psychological base must shift. You must regard the well people who will finance your hospital as partners, not as customers. Remember that people who are prepaying their hospital costs, whether directly through a union plan, or indirectly through their employer, are as interested in a high quality of service as you and your medical staff are, for it is they personally, or their own families, who will be the recipients of your service when their doctors send them to you for admission. They are not "third parties." They are parties of the first part, once removed.

If you call them "third parties," it will be to your disadvantage in discussions with them. The term will suggest that you consider them outsiders. Real third parties *are* outsiders, such as: a business firm that is paying for the care of its workmen's compensation cases; an insurance company which, as it must, is making a profit out of its health insurance business; a Blue Cross plan, if it functions as a representative of its hospitals more than of its subscribers.

These four points need illustration and discussion.

The 110 million Americans who have hospitalization insurance today are just beginning to catch on to the really basic change as current financing of hospitals moves from the sick to the well. Some hospital trustees, physicians and administrators foresee what is happening; some are not yet awake to the change or the meaning of the change.

Informed people, including some public officials and leaders of large groups, are catching on to the fact that the hope of reducing hospitalization costs lies less in greater administrative efficiency, welcome though that always is, than in measures which will reduce the amount of expensive inpatient care utilized. Diagnostic services to ambulatory patients in the hospital would often render certain days of bed care unnecessary. The same result would be expected to follow—and evidence is accumulating that it does follow—from early diagnosis, with prompt and full treatment of illness, from convalescent care, home care, nursing home care, utilized in organized relations with general hospital care as fully as possible. Of course, experiments with these policies may complicate relations with some specialists on hospital staffs, or with medical societies. Many hospital administrators sit uneasily on the horns of this dilemma.

The American public will be little concerned with jurisdictional disputes between doctors and hospitals, once the public understands that improvements in service and economies in money can be had by overcoming or by-passing them. Hospital leadership which has the courage to inform the public on these matters and to try experiments will have monuments erected to its honor by 1975.

HAVE FOUR ALTERNATIVES

Sick people who receive hospital care are passive agents financially, when they must pay as individuals. They get a bill and do the best they can with it. Well people can be active agents, for they have choices as to the way they will prepay their care. The majority of those well people today who have hospitalization insurance have thought only of two choices: (1) Blue Cross service benefits; (2) insurance company indemnity benefits. A growing number of people, however, are thinking of a third choice, namely, self-insurance, which in this instance means direct service plans under various auspices. Examples are the Labor Health Institute of St. Louis and the United Mine Workers Health Program, set up by unions; the Group Health Association of Washington, started as a cooperative; the Permanente plans on the Pacific Coast, initiated by an employer; the Health Insurance Plan of Greater New York, established by a community organization. The bait which these plans offer is that of comprehensive service, meaning hospital, office and home care by general practitioners and specialists, often working as group practice units, plus hos-

(*Continued on Page* 124)

Princeton Hospital's unit for convalescents, geriatric cases, or chronically ill patients was once the home of Princeton University's graduate college. Home was built in the Nineteenth Century, remodeled to serve as 42 bed, long-term nursing unit. An interior view is shown in color on the cover.

Community Hospital Adds a Long-Term Unit

As part of plan to become a true community health center, Princeton Hospital has converted a residence into a nursing home for the chronically ill and aged

RAYMOND P. SLOAN

DEVELOPMENT of a long-term nursing unit as part of the health service of a general hospital, an important recommendation of the Commission on Hospital Care, has become a reality at Princeton Hospital, Princeton, N.J. Last August, the hospital opened such a unit in a remodeled home three blocks from the main buildings. Merwick, as the unit is known, is designed to serve 42 convalescents, geriatric cases, or chronically ill patients, excluding pediatric cases and persons suffering from mental disabilities or communicable diseases. Preference is given to residents of the area served by Princeton Hospital. The next eligible group, regardless of where they live, are the relatives of Princeton area residents. Out-of-town persons not related to Princeton people are admitted if accommodations are available.

The unit operates under policies established by representatives of the hospital board, with Administrator John W. Kauffman serving as executive officer. An executive committee of hospital trustees is the governing body. The medical program is under the jurisdiction of a Princeton Hospital staff member, with a general medical man on a retainer basis to make daily rounds and be on 24 hour call. Five medical residents rotate through the geriatric unit as part of the hospital's educational program. Medical care is included in the patients' fees, but a personal physician may be called at a guest's own expense, provided the doctor has medical staff privileges at the hospital. If the patient's condition warrants it, he is transferred to the hospital; each guest at Merwick signs a statement to this effect when he is admitted to the unit.

(See pictures and text on following pages)

THE AIM IS TO GIVE GUESTS AS MANY COMFORTS AS THE BUDGET PERMITS

Above: Typical semiprivate room at Merwick. Guests may supply furnishings, other than beds, if they wish. Unit will have one employe per guest, compared with two to two and one-half employes per patient in Princeton Hospital.

MERWICK, the gift of Thomas S. Matthews in memory of his mother, was converted from mansion to nursing unit at a cost of $580,000. This included Ford Foundation and Hill-Burton funds, a $250,000 mortgage, and $180,000 in contributions from the Princeton community. Rates are $125 per week for a private room, $100 for a two-bed room, and $75 for a three-bed room. For this amount are provided the services of the Merwick physician, routine nursing care, rehabilitation and occupational therapy facilities, minor medication, meals, bed laundry, and use of all facilities. Estimates of monthly expenses, projected by the administrator, list personnel at $6540 and other expenses at $11,504.80. Income from patients totals about $17,160. Mr. Kauffman believes that 85 per cent occupancy would make the unit break even and provide funds for retiring the mortgage. A stronger financial position would permit a reduction in rates. The aim is to give guests as many comforts as the budget will permit, he says.

Above: One of the two attractively decorated television solariums at Merwick. Below: Main lounge of the home. Tea and refreshments or cocktails are served here daily. Merwick, the popular name for the home, is derived from the initials of Mary E. Raymond, wife of the first owner of the home, and the English suffix, wick, which means house.

Above: Guests enjoy resting or reading on the terrace, which overlooks a small formal garden. Nine beautifully landscaped acres add to the privacy of the home, which is located a short distance from the main buildings of Princeton Hospital. Below: Another view of the formal garden shows fish pool and fountain in the background.

NEEDS OF OLDER PEOPLE HAVE BEEN CONSIDERED IN DESIGNING THE UNIT

RESIDENTS at Merwick are encouraged to lead as nearly normal a life as possible. There are no restrictions on their activities, other than those imposed by the medical staff. Guests are free to participate in the many social and cultural events of the university community. Visiting at the home is encouraged, and friends or relatives can be accommodated for meals or given overnight lodging. Residents' rooms are spacious, with the high ceilings and interesting construction characteristic of old houses. Each room has an adjacent bath. Rooms, lounges and solariums are decorated in soft colors, with occasional bright accents for variety. Residents may supply their own room furnishings, other than beds, if they wish.

Throughout the entire English Tudor style house, the needs of older people have been given consideration. Door thresholds were removed to prevent tripping, bathrooms and showers are equipped with nonskid tile, and handrails are provided on the stairs and in corridors. A two-way intercommunication system connects the nurses' station and all bedrooms and bathrooms.

The rehabilitation program is still in the process of development. A ground-floor room has been set aside for rehabilitation facilities, but hospital officials agree that the program should be flexible enough to be carried out in all sections of the house, under the supervision of the Merwick physician. Ultimately, the program will include therapeutic exercise, light, heat, cold, water, electricity and massage. The overall plan calls for physical therapy, occupational therapy, with a professional worker already in charge, and recreation. On the third floor is a tiny auditorium and stage that will be used for informal gatherings and recreational programs.

Other facilities of the nursing unit, which again are characteristic of normal living, are a beauty shop and a barber shop. Both of these offer complete service to the residents at certain hours of the day. A laundry with washer and drier is provided for those who wish to care for their own garments.

(Continued on Next Page)

Above: The small laboratory at Merwick is equipped for routine work. A hospital laboratory technician will visit the unit daily. Medical care is provided, but guests may call personal physician at their own expense, if they wish, provided doctor has medical staff privileges at the hospital.

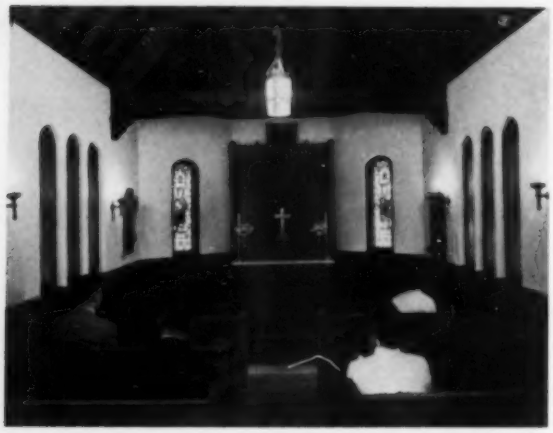
Above: Rehabilitation program, especially important in a unit such as Merwick, is in process of development. Part of ground-floor room for therapy is shown here, but the program will be carried on throughout house, under the supervision of Merwick physician and professional workers.

Below: Laundry room with modern washer, drier and ironing facilities is provided for patients who wish to take care of their personal laundry.

Below: A beauty shop and barber shop are available at certain hours, as part of plan to help patients live as normally as possible in the unit.

Below: A two-way intercommunication system connects nurses' station with bedrooms and baths. Special safety precautions have been taken.

EACH SUPERVISOR IS RESPONSIBLE TO THE HOSPITAL DEPARTMENT HEAD



Above: Interior of chapel at Merwick was designed by Rt. Rev. Paul Matthews, once Episcopal bishop of New Jersey. Home is formally known as Elsie Proctor Matthews Unit, for mother of Thomas S. Matthews, who donated home.

BREAKFAST in bed may start the day, if a guest wishes. A midmorning buffet is set up in the dining room to provide a "coffee break." In the afternoon, tea and refreshments or cocktails are served. Evening snacks also are available. Main dishes for all meals are prepared in the Princeton Hospital kitchen and put in heated food carts to be transported by truck to Merwick. Short orders, breakfasts, salads and so on are prepared in the unit itself.

Once the home of the Rt. Rev. Paul Matthews, Episcopal bishop of New Jersey, Merwick still has the chapel which he added to the house. The stained glass windows, carved oak pews, and altar accoutrements have not been altered, at the express wish of the bishop's son, Thomas Matthews, who donated the house to the hospital. Services are held each Sunday. These are arranged by the Pastors' Association of Princeton, since both Merwick and the hospital are nonsectarian. Announcements of the type of service to be held are distributed several days in advance.

Above: Princeton Hospital volunteer workers greet visitor to Merwick. Below: Nursing supervisor assigned to Merwick rests in her living quarters on the third floor of the old mansion. Nursing staff includes five registered nurses, five practical nurses, three aides, and an orderly. Supervisor is responsible to nursing director at the hospital.

Above: Ambulatory patients are served their meals in this pleasant dining room. A buffet table for midmorning refreshments is set up here each day. Below: Kitchen staff prepares to serve meal at the unit. Main dishes are cooked at Princeton Hospital and sent to Merwick by truck. Dietitian assigned to unit is responsible to hospital dietitian.

Hospitals Must Be More Than Repair Shops

The day of the "repair shop" where ailing people have their acute illnesses patched up, with no thought given to either prevention or follow-up, is rapidly departing, according to the authors of the articles presented here, who look forward to the day hospitals take responsibility for total medical treatment, from preventive examination of the well patient up to and including the rehabilitation of the long-term patient so that he can return to some type of normal social environment and gainful employment.

EDWARD L. BORTZ, M.D., and RAYMOND HOSFORD

WITH the general widespread increase in the number of older people, and since they are more and more the group requiring hospital services, it becomes evident that our institutions must prepare to furnish the services which an aging population requires.

The medical needs of our aging population consist largely of care for long-term illnesses. In the management of these cases, since the onset and frequent recurrence are of an acute nature, the separation of patients in so-called "hospitals for chronic illnesses" is as a rule impractical, inefficient and may be more expensive. Accordingly, division of services within an institution becomes advisable.

Departments within the general hospital, organized and equipped to furnish the necessary complex procedures essential for modern medical care, may be utilized by other departments of the hospital when the need arises. For a great many procedures, patients may be handled on an ambulatory basis in facilities especially designed for this purpose. A large percentage of these will be outpatients. Others will be admitted for comprehensive diagnostic studies, and still other convalescent patients will be transferred from the higher-cost acute general division of the hospital. These inpatients will go to a central dining room for their meals and enjoy hotel type of lounge facilities.

In the British *Lancet* for April 6, 1957, there is a description of day hospitals and night hospitals which have been created where patients may spend the majority of their waking or sleeping hours under a treatment regime and from which they return to their homes for the remainder of the 24 hour period.

Soviet Russia has had day hospitals for mental cases since 1942. For patients who come to these centers during the day from their homes, the emphasis is on occupation and rehabilitation for work. Hospital facilities, however, are also provided.

There are two day hospitals for psychiatric patients in North America, one in Montreal and one in Kansas. The idea is spreading, however, and a day hospital operating successfully among the primitives in tropical Africa has recently been described.

The advantages of day hospital treatment are economic and social. This technic may prove most beneficial for older individuals. The patient keeps his place in the family, as he can spend the night at home, when the wage earners have returned from work.

At Montreal General Hospital there is a night hospital to which the patients come after their day's work. They spend the evening there and receive any prescribed treatment and then sleep until time to go to work.

These hospitals for temporary services are an interesting and probably an important innovation.

Acute illness and catastrophic episodes, such as coronary occlusion, stroke, diabetic acidosis, intestinal obstruction, and accidents, require immediate high efficiency, and often complicated teamwork services. Subsequent care, with prolongation of the illness, as a rule becomes simplified. Accordingly, there is a diminishing need for specialized facilities. Prolonged illness will probably increase

Condensed from a paper presented by Dr. Bortz at the Middle Atlantic Hospital Assembly, Atlantic City, N.J., 1957.

COMMUNITIES WANT POSITIVE HEALTH CENTERS

Hospitals of the future will become positive health centers. Better care of the sick and the injured is on the way.

1. More hospital facilities will be developed for part-time patients who cannot be left alone in their homes while other members of their families are at work.
2. Hospitals will tend to plan, equip and staff units or divisions in accordance with the degree of illness, separating ambulatory patients from acutely ill bed-patients.
3. Greater emphasis will be placed on periodic health examinations for presumably healthy people, to detect abnormal conditions in their initial stages.
4. Health evaluation services will be available and the proper retirement age for individuals will be determined on a biological rather than a chronological basis.
5. More community master planning will be developed to prevent duplication of facilities, equipment and teaching staffs.

Raymond F. Hosford has been director of Lankenau Hospital, Philadelphia, since 1952. Before taking that position, he was superintendent of Bradford Hospital, Bradford, Pa., for 21 years. A fellow of the American College of Hospital Administrators, Mr. Hosford is the author of numerous articles in the field of hospital administration. He is a past president and trustee of the Hospital Association of Pennsylvania, and currently is a member of the association's council on government relations. He received his higher education at Carnegie Institute of Technology.

as the population ages. It must also be evident that sooner or later every citizen will ultimately need some form of medical care.

Another practical point is the necessity for early ambulation. In fact, no elderly person should be kept in bed unless the physical condition absolutely requires it. The longer inactivity is permitted, the more rapidly will the physical condition and tonicity of the patient's muscles and organs deteriorate. Hospital furniture, beds, chairs, dining and toilet facilities must be constructed with the needs of the elderly patient in mind. The elderly should not be isolated except when a serious situation necessitates single-room facilities.

What are the top services which the community expects of hospitals today? Are these institutions to continue merely as repair shops? Far-reaching changes are in process. The public is becoming more and more health conscious. The need for more intensive study of the precursors of the various common diseases is being recognized by our leading educational institutions and industries. Many corporations are deeply disturbed that promising and brilliant executives, in training for years to occupy responsible positions of authority, are suddenly eliminated by an occlusion or a stroke.

Our medical leaders are altering their views concerning the long-range approach to this kind of problem. Examination at regular intervals may reveal a steady, unhealthy gain in weight; a slow insidious increase in the blood pressure; accumulating exhaustion from prolonged hours of stress, and the incipient signs of nervous collapse. A small tumor, when identified, can often be eradicated before it becomes malignant; there are many sly evidences of disease in-the-making which, when recognized, and effectively neutralized, may save the individual from a later catastrophe. Here is a new realm for medical service. Since many of the procedures for studying presumably healthy individuals are likely to be complicated, time consuming, and expensive, more and more physicians of the community will look to the hospitals to offer the services.

DOCTORS MUST GEAR THEMSELVES TO TWO NEW CONCEPTS OF MEDICAL

MOST doctors and nurses have become geared to diagnosis and therapy of the acutely ill as the main concept of medical practice. Two new concepts align themselves on either side of the care of the acutely ill. One is preventive medicine and the other is rehabilitative medicine. The combination of all three concepts should give us some vision into the future of the physician and the hospital.

The prevention of disease has scarcely begun. We can look forward to the development of more sensitive instruments and methods to be used for the detection of disease in its earliest stage of altered physiological processes, or for the indication for preventive therapies before disease has actually been manifested. The advancement of preventive medicine will depend upon physicians and allied scientists to elicit further the causes of disease, making it possible to prescribe positive measures in the maintenance of health. Hospitals must understand and accept the concept of preventive medicine to be able to provide the comprehensive medical workshop for the physician and his collaborators.

Dr. Buerki is executive director and Dr. Howell is assistant director, Henry Ford Hospital, Detroit.

Coupled inseparably with both prevention of disease and the treatment of active disease is the principle of rehabilitation. Rehabilitation, it is believed, is a comprehensive term which can be applied to the long-range therapy of any patient with any disease process. Just as it can apply to teaching the amputee to walk again with prostheses, it can be used to prepare the coronary artery disease patient for his future. Just as we should teach the deaf child to speak, we should prepare the emotionally unstable patient to live in society. On the one hand, rehabilitation is a medical philosophical concept but, on the other hand, it is a practical therapy. It can be a preventive therapy in offsetting further crippling from a disease process. It can be an active therapy for a patient in the throes of an acute or chronic illness and it can be a corrective therapy for the resultant impairments left in the wake of a patient's disease. Rehabilitation is the mobilization of the existing normal physiological components and the modification of pathological defects in the human body into a functioning state as near the normal range as possible.

While it is recognized that hospitals now have problems in meeting the financial and personnel demands created by modern medical diagnosis and treatment, nevertheless, both the medical profession and the public expect hospitals to press on to participation in programs of preventive and rehabilitative medicine. There will be the expensive requirements of additional technical equipment and skilled personnel to manage the services.

In rehabilitation, one of the prime requisites is the relatively large amount of space needed for the program, a genuine problem in most if not all hospitals. A great deal of clinical investigation will be required to learn new technics and methods of administering the programs effectively. Provision for rehabilitating a patient will have to be thought about when he first enters the hospital, will have to be initiated during his stay, and must be continued after he is discharged. Continuing therapy for patients may well mean outpatient services, but it may also mean supervised therapy activities at home. While many community rehabilitation programs are conducted apart from the hospital, some larger hospitals should have complete rehabilitation services of their own and all hospitals should have enough of a program to start therapy even though it is completed under a community program.

A program of rehabilitation is expensive, not only in equipment and

The changing attitudes of people today with reference to hospitals necessitate a broadening of the services that will be required in the future. In fact, the time has arrived when the medical profession and the hospitals, too, should become health oriented rather than sickness oriented. The changing hospital today is developing into the positive health center of tomorrow, and it will continue to extend its influence for a healthier and happier community.

Hospital management with vision has come to realize that the least expensive way to deal with illness is to prevent it in the first place, and, where this is not possible, to discover and diagnose illness early, so that treatment may be more effective. Every intelligent person should submit to a minimum basic physical examination annually. By minimum basic examination, we mean something more comprehensive than most family physicians are equipped to do in their private offices, but something that is less comprehensive and less expensive than the conventional diagnostic clinic. Such a service, well conceived, efficiently managed, and ethically conducted, can make a valuable contribution to the health needs of the community.

A health evaluation service would fit perfectly into this concept. Should corporations continue to retire executives and skilled personnel at any arbitrary fixed age, when it is well known that man ages biologically, rather than chronologically? Many men have attained their greatest achievement well after they have reached the conventional retirement age of 65. Industry will undoubtedly be willing to pay for a health evaluation service (not to be confused with an ordinary physical examination) to determine when an employe has reached the practical retirement age based on both his physical and his mental status.

With greater ease of transportation and communication, the advisability of organizing hospital services with reference to total community or state needs has resulted in a number of progressive states of the nation creating cooperative medical service programs whereby patients may be re-

Dr. Edward L. Bortz is chief of medical service at Lankenau Hospital, Philadelphia, a position he has held since 1932. A past president and vice president of the American Medical Association, he also was a founder of the World Medical Association. He is assistant editor of "The Cyclopedia of Medicine, Surgery and Specialties" and the author of "Diabetes Control" and numerous medical articles in the fields of nutrition, metabolism and geriatrics. Dr. Bortz is a graduate of Harvard College and Harvard Medical School; he took postgraduate work at Mayo Clinic and several universities.

CARE: PREVENTION AND REHABILITATION

ROBIN C. BUERKI, M.D.
JAMES T. HOWELL, M.D.

personnel but also because it is long term and because there is often no clear endpoint as to when the patient has received maximum benefit. We must ask ourselves how are we to pay for these programs. We must remember that most of the patient's money has already been spent in the care of his acute problem. Will it be a program paid for by tax dollars? Will the money come from a third-party plan, whether it be insurance, governmental or maybe industrial funds? Can a patient afford the service out of his income? There is no ready answer for this problem, but at the same time it is only realistic that we should plan to operate the service on a "break-even" basis. Thus, schedules of charges will have to be proposed for all the services rendered.

Among the requisites of a rehabilitation program will be the close liaison between the hospital and all the community health resources, including a separate rehabilitation center. The liaison must be closely maintained between the physician and the associated rehabilitation services as well as with the patient's home circumstances. In this area, visiting nurse's service may have to be augmented. The social service department may well assume the responsibility for the coordination of rehabilitation activities as a professional contribution. It would be well to examine some possible stumbling blocks in the path of rehabilitation. One of them is the payment of pensions for disability. A man injured on the job is provided medical care under acts of compensation, and provisions are also made for allowances for disability. In medical circles there is considerable discussion today that there are grounds for conflict between disability pension plans and rehabilitation programs, for if medical planning is effective, the patient should be able to return to some gainful employment. In these discussions it is being pointed out that human nature is inclined to accept the easier road of seeking the greatest disability pension which the injury might justify. In many areas, industry has not as yet fully sanctioned the expenditure of additional money for rehabilitation beyond the money it provides for the medical care of the acute accident. By the same token legislation is being proposed for pensioning the disabled among older age groups. The resolution of these conflicting views is not yet at hand. It is reasonable, particularly in view of recent discussions, to assume that these pension plans may hinder the development of rehabilitation programs.

As a hospital contemplates comprehensive medical care for the patients it serves, it will first need to provide the full gamut of technical equipment and the skilled professional people to administer modern medical diagnosis and therapy of acute problems. Then, there will need to be the provision of these services for the outpatient who can be managed in ambulatory clinics. Expanding both the inpatient and outpatient services to include regular preventive health examinations for "well patients" will then permit early diagnosis and more effective medical therapy. The care of the chronically ill in hospitals is probably the next step in an orderly approach to comprehensive medicine in hospitals. The rehabilitation program is inseparable from acute and chronic care just as it is inseparable from inpatient and outpatient care.

One of the chief criticisms leveled against the medical profession today is that of impersonalized care. This criticism has its roots tangled with those of scientific progress. Through rehabilitation there is great promise of the return of some of the art of medicine for these programs become highly personalized, integrating medical and psychological care with home and working environments. This may well be the most important by-product of rehabilitation medicine.

ferred to particular hospitals, or teams of medical experts may be transported to outlying institutions when the necessity arises. In the training programs for interns and residents and other professional personnel, a highly fluid and flexible cooperative plan for rotating personnel from medical centers to hospitals in small communities up to 100 miles away has created opportunities for a superior type of medical service, and a broader experience for those in training for professional careers. Top professors and chiefs of the various departments in medical schools would profit greatly by occasional excursions into smaller communities. In this way they would more clearly realize important problems which arise locally.

In the last quarter century disease control resulting from scientific advances, new diagnostic and therapeutic equipment, and new wonder drugs has increased hospital costs enormously. Inflation has likewise contributed to higher costs. But when one considers the lives that have been saved, the shorter average hospital stays, less time lost from gainful occupations, and the longer life span of our population, no thinking person will deny that in no other area of our economy can one obtain so much of value for so little cost.

Cost of medical care for those 65 years of age and beyond is considerably higher than for the general population. When the Health Information Foundation conducted its research study to determine the family medical costs, it was ascertained that individuals 65 years of age and over spent an average of $36 for physician costs. This is 44 per cent more than the average expenditures by the general population. The hospital costs for those over 65 years of age were 92 per cent more than the average for the general population. The aged, furthermore, spent 60 per cent more than the general population for medicines and other devices. Many of our elderly population are in a predicament because, at the time their need for medical care is greatest, and its cost is increasing, their incomes are diminishing or cease to exist. Accordingly, voluntary health insurance programs are an important asset by which the aged can protect themselves against the severe impact of medical expenses.

At the present time, approximately 35 per cent of the nation's older citizens are covered by some form of health insurance. The percentage should be much higher.

Sound fiscal policy requires that expenses be met. As individuals grow older they require more and more medical and hospital care. This is both a social and economic problem. There is a great need for insurance coverage which will permit policyholders to continue their insurance beyond the 65 year period. The insurance program should stand solidly on its own merit and its premiums must be adequate to provide the policy-holders the protection they need. It should not be necessary for voluntary insurance to expect subsidy from the government, but the problem will not solve itself. There is no cheap or easy way to meet the health needs of our aging population. Premium rates will have to be based on actuarial experience. It may be necessary for Blue Cross and/or private insurance companies to augment their pay-as-you-go type of health insurance with a long-term higher premium policy that would become paid up when the policy-holder reaches age 65. This would be similar to the paid-up type of policies that have long been popular in the life insurance field. #

REHABILITATION IS A LOGICAL ADDITION TO THE HOSPITAL'S SERVICE

ROBERT E. NEFF

REHABILITATION is fundamentally a medical service. The hospital is the workshop of the physician and deals exclusively in medical service and related needs. Consequently, it is logical to join hospital and physician in the program which will exercise management of the case in the interest of all the medical and rehabilitative needs of the patient. The general hospital has a real opportunity as well as a challenge to broaden its services as it recognizes its responsibility as a health center concerned with the total needs of the patient.

Comprehensive rehabilitation in a general hospital is recognized as a comparatively new concept and obviously there are limitations that must be reckoned with. On the other hand, a service so vital to the growing needs of the patient eventually should be accomplished just as many other types of special hospital services have been provided in the past through the demands of modern medical practice.

The reward to the patient when he finds his entire medical needs guided and managed from a single source where the responsibility is already undertaken for his total medical treatment is most significant and will give us more license to designate the modern hospital as a rehabilitation center. As efforts are directed toward centralizing responsibility for rehabilitation, the position of the general hospital as

Mr. Neff is administrative consultant, Indiana State Board of Health, Indianapolis.

Illustrations for this article are from the film strip, "Professional Education," produced by the National Foundation for Infantile Paralysis, 301 East 42d Street, New York City.

Instead of discharging "cured" patients, the new concept is rehabilitation

Comprehensive care calls forth the efforts of many groups of workers

an adjunct in this area is pushed forward.

The physician must be responsible for the total medical needs of the patient, including rehabilitation care. The doctor is a busy man but if he gets interested in a problem he will work harder than anyone else. Obviously the patient who needs medical or surgical preparation for rehabilitation should be in a hospital.

Few phases of rehabilitation are completely removed from the medical problem where the judgment and the direction of the physician are essential. Rehabilitation processes grow out of, and for the most part are determined by, physical evaluation based on a complete and comprehensive examination and history taking. In this evaluation the factors of importance are naturally the nature and course of the underlying disease, the emotional factors, the socio-economic factors, the vocational possibilities, and the presence of other diseases of significance. All processes of physical evaluation involving consultation among physicians of various specialties and types of medical practice can be procured to the best advantage in a hospital where we find an organized medical staff. Here is present a continuity of team action with a potential of good medical control over the patient's treatment from the period of acute illness through his eventual and final rehabilitation stages.

Until recent years the great majority of the medical profession looked upon rehabilitation as an extracurricular activity of medicine, something dealing with social work, vocational training, and other welfare activities with but few implications for medicine. Today, however, that trend is being reversed and although there are still many physicians who are unfamilar with the aims and procedures of comprehensive rehabilitation, medicine is beginning to recognize that medical care cannot be considered complete until the patient with a residual physical disability has been trained to live and work with what he has left.

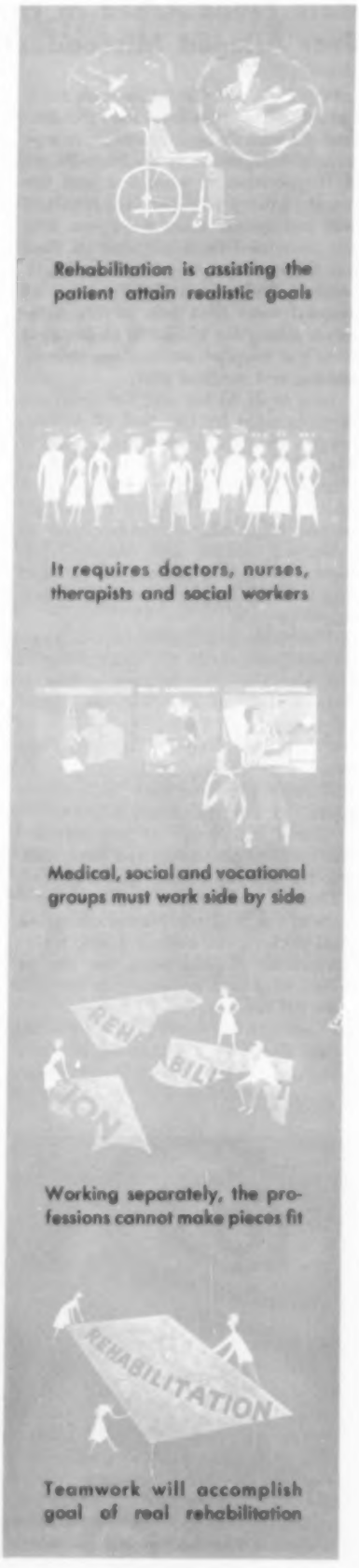
The basic philosophy should be recognized that the doctor's responsibility does not end when the acute illness has ended or surgery has been completed; it ends only when the individual is retrained to live and return to some type of normal social environment. This basic concept of the doctor's responsibility can be achieved if rehabilitation is considered an integral part of medical and hospital services. Any program of rehabilitation is only as sound as the basic medical service of which it is a part.

Since the feasibility of retraining is determined on the basis of diagnosis and prognosis, naturally, accuracy of a high degree must be exercised in this process. Costly and damaging physical, emotional, social and vocational sequelae of the acute disease process can be alleviated or minimized by sound medical direction and a high quality of diagnostic care.

To ignore the development of rehabilitation services within general hospitals is to contribute to the continued deterioration of many less severely disabled persons until they, too, reach the severely disabled and totally dependent category. Neglect of disability is far costlier than an early program of rehabilitation which may restore the individual to the highest possible level of physical, economic, social, emotional and vocational self-sufficiency. Physicians who are experienced in handling the problems of rehabilitation are quick to vouch for the fact that rehabilitation services can best be provided by the hospital where bed service is available in conjunction with other hospital services, such as x-ray and laboratory. This is perhaps the best argument for a hospital-connected rehabilitation service.

I do not minimize the chief problems faced by the hospital that attempts to provide comprehensive rehabilitation, which embraces vocational counseling, psychological services, prevocational work adjustment, speech and hearing services, vocational placement, and facilities for treating disabled individuals for the activities of daily living. It is obvious that the medical practitioner cannot have at his disposal in the hospital all of the various facilities needed for rehabilitation of the severely disabled, but he can, by means of referral and direct communication, make use of the other agencies in the community that offer various types of rehabilitation services, particularly in the care of long-term patients.

With the emphasis placed here on the general hospital as a rehabilitation center there has been no intent to deprecate the many independent agencies as vital parts in the community program. Much needs to be done to bring independent agencies together in a more closely coordinated and integrated program of rehabilitation activity, where under centralized direction the follow-through on the patient can be effected to a high degree among agencies as needed in each individual case. Without such central direction the patient finds it difficult to obtain rehabilitation and the necessary follow-up care which the modern concept dictates in the care of the whole patient.



State Probe Asked in Hospital-Surgeon Feud Over Alleged Misconduct, Improper Practice

PONTIAC, MICH.—Proposals for a legislative inquiry into the relationship of hospitals and doctors, and separate investigations by the State Board of Registration in Medicine and the county prosecutor's office, resulted here last month when a surgeon who was dismissed from the staff of Pontiac General Hospital for alleged misconduct and repeated infractions of hospital rules filed suit for reinstatement, asking for $250,000 in damages from the hospital, its trustees, administrator and medical staff.

In a reply to the suit for reinstatement brought by Dr. Neil H. Sullenberger, Hospital Administrator Carl I. Flath listed 25 instances in which he charged the offending surgeon had been guilty of failure to follow accepted standards of practice and of "abusive, profane and obscene" behavior, including threats of physical violence against staff members and associates.

Following publication of sensational headlines about Dr. Sullenberger's suit and the charges against him in Pontiac and Detroit newspapers, State Representative Leslie H. Hudson of Pontiac asked the legislature to appoint a committee to investigate the Sullenberger case and "this whole matter of hospital-doctor relations."

Public confidence in hospitals and the medical profession had been shaken by the episode, Hudson said. "There is confusion as to the exact nature of the relations between hospitals and doctors," he added, asking for an immediate appropriation for the investigation and authority to examine hospital records.

Meanwhile, investigators for the State Board of Registration in Medicine and the office of Oakland County Prosecutor Frederick C. Ziem had interviewed Flath and Dr. Sullenberger and were scheduling talks with other hospital staff members and employes in full-scale investigations of the controversy.

Following a lengthy discussion of the case at a closed meeting which reportedly had "overflow attendance," the Oakland County Medical Society, by a substantial majority, approved a resolution commending the hospital for its support of "the highest standards of medical practice under its constitution and by-laws and rules and regulations." The resolution also expressed approval of hospital regulations aimed at ensuring the professional qualifications of physicians as "vital to the public interest."

ANOTHER LAWSUIT PENDING

As attorneys for the city-owned hospital prepared for the court battle with Sullenberger, they were also planning the hospital's defense in another lawsuit in which four general practitioners on the staff were demanding unrestricted surgical privileges, claiming the hospital had no right to make rules and regulations limiting their practice of medicine.

In its reply to this suit, the hospital pointed out that the plaintiff physicians had agreed to abide by the hospital's constitution and by-laws when they joined the staff, that the hospital had the right and obligation to enact and enforce reasonable rules and regulations, and that plaintiffs had not met the standards of experience and proficiency required by the rules.

Suspension of hospital rules would result in withdrawal of the hospital's accreditation by the Joint Commission on Accreditation of Hospitals, the reply stated, adding that such withdrawal "can only result in the lowering of the standard of hospital care and treatment offered the public and . . . termination of the hospital's approved training program." In this event, it added, "The citizens of Pontiac would not be able to receive the high standards of medical care and attention presently available, for the reason that the most skilled physicians and surgeons would not be willing to practice in nor bring patients to a hospital where the standards of care and treatment did not meet the minimum requirements of the Joint Commission on Accreditation."

In the Sullenberger case, both sides tried to make capital out of the fact that, following an inspection last summer, the hospital was dropped from full to one-year approval by the Joint Commission.

Explaining its action, the Commission had cited "failure of the medical staff to take appropriate corrective action to maintain proper standards of practice at the hospital."

According to Dr. Sullenberger, this finding by the Commission was indicative of a general breakdown of discipline in the hospital, and especially in the operating room, where he charged residents, interns and nurses with laxness in obeying his orders. Because of this lack of cooperation, Dr. Sullenberger acknowledged, he had "become incensed at certain personnel and made his feelings known."

Denying that any general breakdown of morale or discipline in the hospital existed, Flath replied that one of the primary reasons the hospital had been placed on probation for one year by the Joint Commission was its failure to take any action to suspend or curtail Dr. Sullenberger's privileges. "If plaintiff's (Dr. Sullenberger's) suspension is made permanent and plaintiff is dismissed as a member of the hospital staff, there will be little difficulty in securing complete reinstatement from the Joint Commission on Accreditation at the end of the probationary period," he declared.

A graduate of the University of Arkansas Medical School and diplomate of the American Board of Surgery, Dr. Sullenberger, now 42 years old, was a flight surgeon for five years during World War II and returned to take residency training in surgery at the University of Michigan Hospital, which he left abruptly in 1950 following an altercation with a Negro girl operating an elevator in the hospital. Later, it was reported, he was found not guilty of an assault charge.

Joining the staff of Pontiac General Hospital, he remained in practice there until 1954, when he left Pontiac—with a letter of recommendation from the hospital, according to

(*Continued on Page 129*)

Photograph from "Pontiac Press."

Left: Dr. Neil H. Sullenberger, who is bringing suit for $250,000 damages against Pontiac hospital, of which Carl I. Flath (right) is administrator.

Labor Wants Health Security in Social Security

In previous issues of The Modern Hospital and elsewhere, hospital administrators have had an opportunity to study statements by the American Medical Association and American Hospital Association on health care of the aged, and especially the Forand Bill. Here is a statement on this subject from another interested and influential group—organized labor.

NELSON H. CRUIKSHANK

WE HAVE now had 22 years' experience in the United States with a nationwide system of social insurance as one of the major defenses for families against economic disaster resulting from old age or death of the breadwinner. Social security based on social insurance is no longer a theory. Our present system of old-age and survivors insurance and disability insurance, though far from perfect and though not meeting all the needs, is now paying monthly benefits to 11 million people. It has never defaulted on a benefit payment and studies by Congress and independent citizen groups have pronounced its fiscal arrangements to be sound.

Because this system has been found economically feasible and because in terms of human dignity it has proved socially desirable over the older methods of meeting family economic needs, labor has been interested in extending its proven principles to meet other critical areas of human need.

With all its good features, old-age, survivors and disability insurance is still inadequate. Monthly benefits are too low, so that the average primary benefit paid a retired worker is $64 a month. For a retired worker with an aged wife, the average payment is only $108 a month or $25 a week. A widowed mother with two children receives $145 a month.

Persons 65 and over need to use on the average more than double the amount of hospitalization as compared with the general population. Their needs for other medical care are likewise higher. The great majority have low incomes. Two out of three have no form of health insurance.

Our proposals to help overcome these inadequacies are embodied in the Forand Bill, H. R. 9467, which has two major features. It would raise benefits by adding $5 to $10 a month to present cash monthly payments and by increasing benefits for future beneficiaries by 10 per cent on the average, with a larger increase for higher income people, who would also make larger contributions than before. Equally important is a new program of health benefits for persons eligible for old-age and survivors insurance benefits.

The cost of hospitalization up to 60 days in a 12 month period would be covered. Admission must be on certification by a physician. In order to encourage the development of skilled nursing facilities and relieve the burden on hospitals, skilled nursing home services would be covered on certification by a physician and following hospital care for the same conditions. Payments would be made in a 12 month period up to 120 days for the hospital and nursing home care combined. The cost of surgical services would also be covered.

The bill provides that the costs shall be paid from the old-age and survivors insurance trust fund.

The Secretary of the Department of Health, Education and Welfare would administer the program. He could make agreements directly with providers of service or with their authorized representatives. He would be permitted to use the services of private nonprofit organizations for administrative purposes.

The patient's freedom to choose his physician would be preserved. Special provisions are included to prevent government interference with the practice of medicine or with the administration of any hospital or nursing home.

Readers who are interested in more details may wish to obtain a copy of the bill and explanatory materials about it that are available. It is planned as a package, with necessary financing provisions, including higher contribution rates (¼ per cent more for employers and employes and ⅜ per cent more for the self-employed).

In explaining the health proposals Mr. Forand stated: "I shall welcome information and comments that might make them still more effective. They are based on much recent experience under private and public programs but their present details are not necessarily the best that can be drafted or the final ones that I shall support."

Labor's consideration of these proposals has already benefited from discussions with many health experts. We are flexible in our approach, not bound inevitably to this particular pattern. But we have not heard of any other proposal that will meet the health costs of the aged in a manner consistent with human dignity and the special requirements of people with low incomes.

The American Medical Association

Nelson H. Cruikshank is director of the department of social security of the A.F.L.-C.I.O. He has held this post since 1956, although his association with the labor movement began more than 30 years ago, when he joined the Seafarers' International Union. Mr. Cruikshank has held many positions in the labor field, has been a U.S. representative to United Nations groups, and is a member of the Statutory Advisory Council on Social Security Financing. For several years he was a member of the National Hospital Advisory Council.

has opposed the Forand Bill but has not come up with any specific alternative proposal for the health problems of the aged. It confines itself to criticizing our proposal as socialized medicine. The same term was applied in earlier years to bills for hospital construction and long-term disability insurance. Years ago, even workmen's compensation and voluntary health insurance plans were opposed. In fact, we are beginning to wonder how many times medicine can be "socialized" in the United States!

We have been disappointed that the board of trustees of the American Hospital Association has not backed the Forand Bill, but we note that it has again affirmed the need for some type of federal legislation and that it is continuing study of various proposals, including the possible use of the old-age and survivors insurance system.

MEANS TEST UNACCEPTABLE

The American Hospital Association is convinced that retired aged persons face a pressing problem in financing their hospital care. The association now recognizes that any proposal involving a means test is unacceptable to many persons. Organizations of the public welfare administrators and of social workers have likewise recognized that many needs of the aged are not being met. They favor action through old-age and survivors insurance.

Three major types of gains will result from the health sections of the Forand Bill:

1. Aged persons and survivors will receive specified health benefits as a matter of right so they will receive proper care more promptly and will be protected from the financal disaster and dependency which major illness otherwise often brings.

2. Hospitals and group plans will be relieved of substantial financial burdens which now often raise unit costs, with attending problems of many kinds.

3. More money will be made available for additional facilities and services, both directly, through payments for covered persons, and indirectly, as funds for new services become available under private plans which now partly meet costs for the aged.

As the American Hospital Association now recognizes, voluntary insurance alone cannot meet the needs of the aged in the field of medical care. Their medical expenses are higher and their incomes are substantially lower. Most private insurance premiums rise rapidly with age. In addition, in present voluntary plans coverage may be limited to new conditions. It may be refused altogether for reasons of health or age, or it may be canceled just when needed most.

Some retired workers benefit from continued health insurance protection won by our unions under group plans. Valuable as this approach is, it has definite limitations since the extra cost must be borne by the group, directly or indirectly, thus holding down the benefits for employed members which may be bought through total available contributions.

Old-age and survivors insurance has many advantages over commercial insurance as a vehicle for paying for health care of the aged or for survivors. The cost of the program does not have to be paid by the aged themselves after they have already retired and their incomes have accordingly been reduced. Instead, contributions made during years of full earning capacity are available. The retired person pays nothing.

Because the program covers nine out of 10 jobs, its cost per person is relatively low. Only 2 cents out of each dollar received as contributions now goes for administration.

I now turn to current criticisms against the social security system. Many of these attacks arise from a failure to differentiate social insurance from commercial insurance. A sound government program does not need to follow the practices of commercial insurance. For example, it is true, as charged, that there is no contract between the government and the individual beneficiary. But the Congress has made a commitment that benefits will be paid and has provided an adequate method of financing them. No Congress is likely to torpedo a program to which more than 107 million living Americans have contributed.

The stability and soundness of the trust funds continue to be under attack. It is not commonly known that the Congress set up a board of trustees which is required to report annually on the expected operation of the trust funds during the next five years.

The report of this board on March 1, 1957, should end any doubts about the financial soundness of the system. The board then included Secretary of the Treasury Humphrey, Secretary of Labor Mitchell, and Secretary of Health, Education and Welfare Folsom. All three were appointed by President Eisenhower. They said that under continued favorable economic conditions the income of the trust funds "will be wholly sufficient during the five-year period immediately ahead to meet aggregate disbursements of the programs during this period." Their estimates further into the future showed the reserve for old-age and survivors insurance rising substantially by 1990 even under conditions of "high cost."

While benefits may slightly exceed income in 1959 and perhaps in 1958, the O.A.S.I. trust funds are not expected to fall below $21 billion before the rise in contribution rates now provided in existing law revives the upward trend in 1960.

In 1956 the A.M.A. made dire predictions about abuses under long-term disability insurance. It is revealing to note that the disability insurance trust fund has already risen to half a billion dollars, while the outlay in October was less than $12 million.

Far from discouraging individual initiative and free enterprise, social insurance strengthens them. People know that the fruits of years of labor will not be swept away by long periods of illness, unemployment or disability. They are assured of some income in their old age, and their families know that they will not be impoverished through having to spend huge amounts for emergencies.

If a person earns more money in his working years, his benefits will rise accordingly. If he saves substantially, he will enjoy the fruits of those savings, not have them drained away in the absence of insurance, or be forced to use them up before public assistance becomes available.

MANY PROBLEMS REMAIN

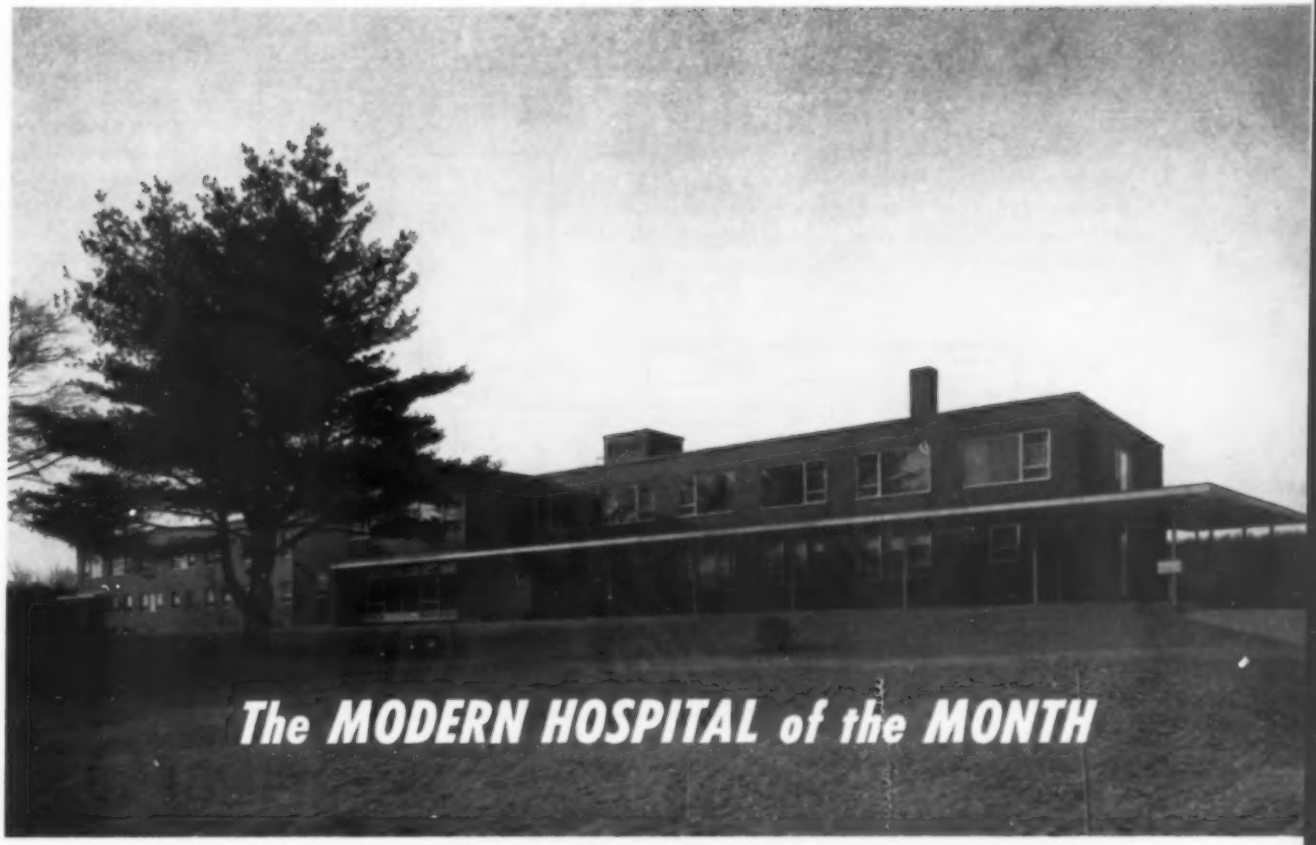
While the value of old-age and survivors insurance has been amply demonstrated and its principles fully vindicated, we realize that many difficult problems are involved in the addition of medical benefits such as we are proposing for the aged and for survivors.

We appreciate the advice we have already received from doctors, hospital directors, and other experts in the field of health. We hope many more will examine our proposals and give us comments based on an intimate knowledge of health problems which we do not pretend to have.

We realize that their interests, too, are at stake, and that solutions should take these interests into account. It is a wholesome sign, we believe, that our hospital proposals are not accepted at once simply because of the lure of federal money!

We in labor feel that we have the same interest as professional people in the health field in high quality of care because we and our families are the people who depend on such care.

We are encouraged by the knowledge that there are many men of good will in the health professions who share our concern over preventable suffering and who favor expansion and adaptation of health methods to meet essential human needs.



This PLAN MAINTAINS a GOOD BALANCE BETWEEN ECONOMY OF BUILDING and MAINTENANCE EXPENSE

The hospital was designed so that it could expand, which was just as well inasmuch as the bed complement had to be increased right away

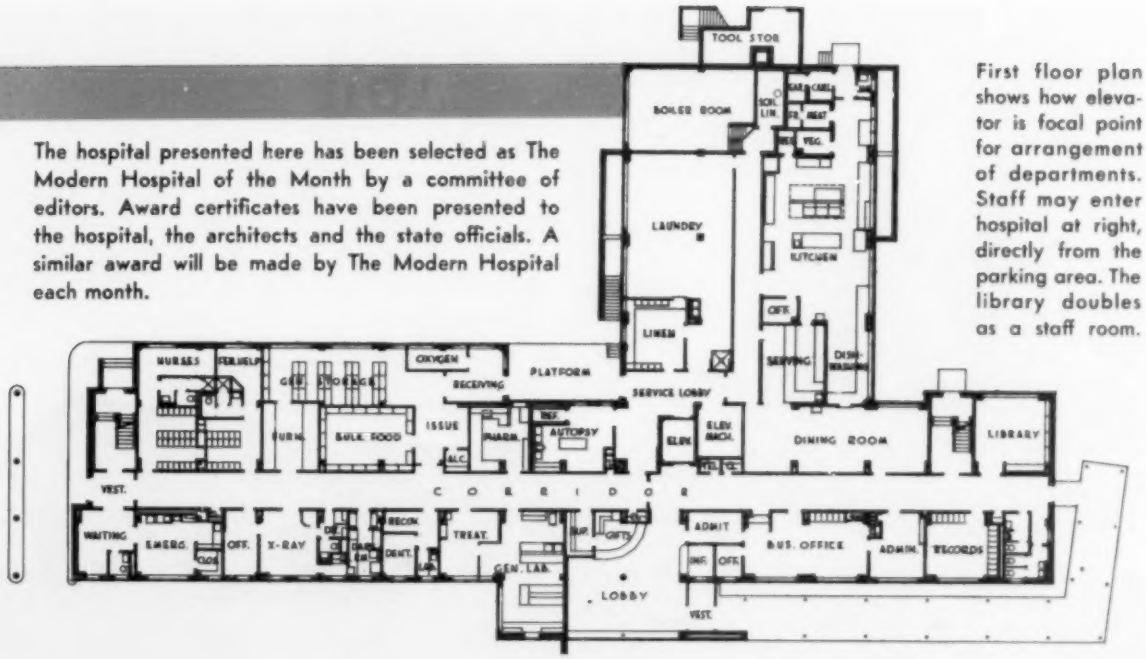
ELBRIDGE L. ATWOOD

WEBSTER District Hospital, Webster, Mass., is a typical small New England hospital, started in 1929 in a large residence of wood frame construction. By 1951 a new building was being discussed and community response culminated in the modern structure of concrete and masonry illustrated in these pages. The rolling site overlooking a lake creates a pleasant country club atmosphere which is enjoyed by the patients through large picture windows in each room.

Economy is a prime consideration with most of our clients and Webster District was no exception. It was necessary to devise a scheme that would provide a compact, workable unit with the various departments so related that maximum efficiency in administration could be obtained. To do this, a structure of two floors and partial basement was selected, with three wings formed into a "T" and the elevator centrally located in relation to all functions. Consideration of future expansion was not overlooked,

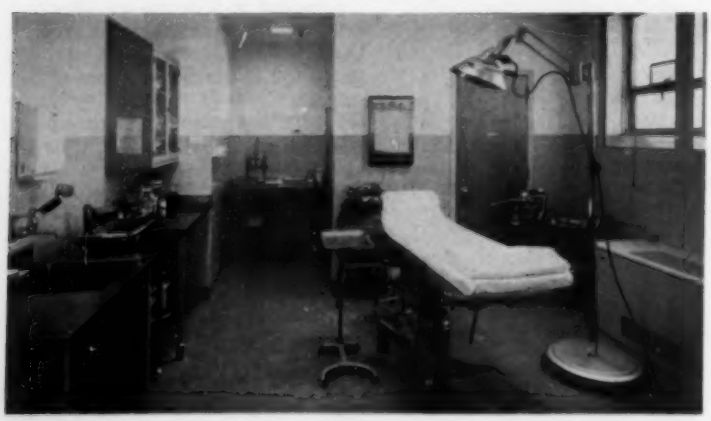
Mr. Atwood is a member of the firm of Aisner and Atwood, architects and engineers, Boston. The hospital was designed by Aisner and Atwood and L. W. Briggs Associates, Worcester, Mass.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.



First floor plan shows how elevator is focal point for arrangement of departments. Staff may enter hospital at right, directly from the parking area. The library doubles as a staff room.

FIRST FLOOR PLAN



Above: The attractive lobby of Webster District Hospital. Admitting and business offices are directly opposite gift shop. Below: Emergency room is located at the far end of the first floor, near ambulance entrance.

as the structure is designed to carry an additional floor.

It will be noted from the plans that most of the ancillary services are on the first floor, while all patients are on the second floor, with central sterilizing, operating, delivery and nursery departments near by in a separate wing. The patient areas are subdivided into medical-surgical, pediatrics and maternity units, all with convenient relation to the elevator and service departments and properly isolated from each other. Food service to patients is direct from the kitchen with trays served from food carts, thus making necessary only a small diet kitchen on the second floor for between-meal nourishment.

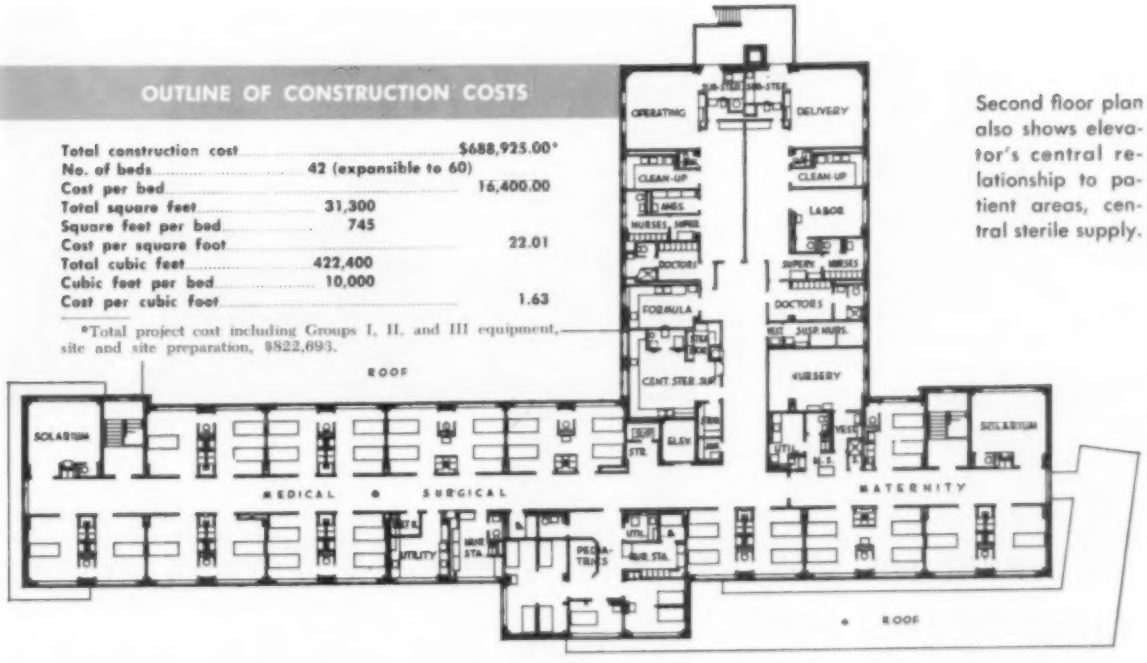
In arranging the patient wings, the need for flexibility was given careful consideration. It will be noted that normal patient capacity is set at 42, but toilet, lavatory and wardrobes are provided at solariums to make them convenient for use as small wards. Each single room is of proper area for two-bed rooms and under emergency conditions 55 patients may be accommodated, within limits established by hospital codes. Two rooms adjacent to the maternity unit are arranged to be interchangeable with the medical-surgical patients, for further flexibility.

A careful separation of departments on the first floor was worked out, again with the elevator at the focal point. One wing provides for kitchen, dining room and laundry with boiler

OUTLINE OF CONSTRUCTION COSTS

Total construction cost		$688,925.00*
No. of beds	42 (expansible to 60)	
Cost per bed		16,400.00
Total square feet	31,300	
Square feet per bed	745	
Cost per square foot		22.01
Total cubic feet	422,400	
Cubic feet per bed	10,000	
Cost per cubic foot		1.63

*Total project cost including Groups I, II, and III equipment, site and site preparation, $822,693.



SECOND FLOOR PLAN

Second floor plan also shows elevator's central relationship to patient areas, central sterile supply.

room and shops below. In part of another, the central storage department has direct access to the receiving platform which also connects to the laundry and serves the autopsy room. It will be noted that the autopsy room is only a few steps from the elevator door in the service lobby.

In this same wing, personnel locker suites are located near the stairs, the emergency room is located at the end with adjacent ambulance entrance, and x-ray, dental, treatment, laboratory and pharmacy facilities are conveniently arranged between emergency and administration departments. The administration area is approached from near-by parking facilities through a spacious waiting lobby with adjacent gift shop, information and admitting offices. This waiting space leads directly to the elevator and business offices. A staff room and library with separate entrance is located at the extreme end of the administration department and near the parking area. The plan provides for a smooth flow of traffic within and surrounding the building with minimum of interference from one department to another.

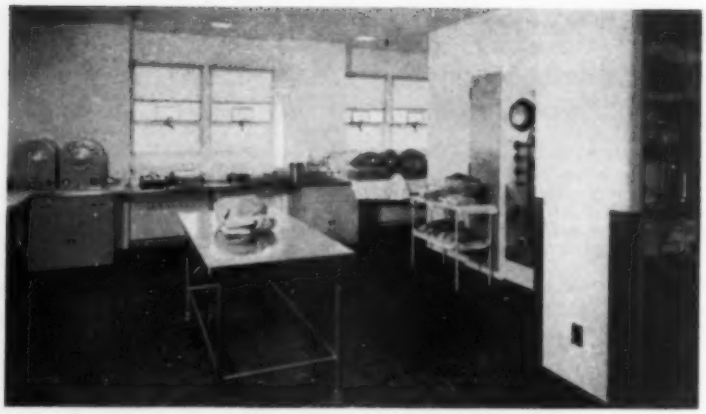
Toilets equipped with bedpan cleaning devices connect to each patient's room, except in the pediatrics department, which adds to the convenience of both patients and staff. Oxygen and suction are piped to all patient rooms and other rooms normally requiring these services. Nurses' calling and doctors' paging systems are provided, as well as doctors' in-and-out

Above: Lavatory, toilet and wardrobes were installed in solariums to make them convertible to four-bed wards, such as this, when necessary. Below: Kitchen is near dining room and elevator to second floor for serving ease.

register. Some rooms are provided with telephone connections.

Air conditioning has been limited to operating, delivery and labor rooms and nurseries. Fresh air is introduced in each floor to balance negative pressures created by exhaust ventilation.

A good balance has been maintained between economy of building cost and maintenance expense in selection of materials.



Central sterile supply department, on second floor, is convenient to elevator, linen closet, patient areas.

Administrator says:

THE DEMAND FOR BEDS OUTRAN THE SUPPLY WITHIN THE FIRST MONTH

HULDA E. STEIN

ON NOV. 28, 1955, 25 patients were transferred from an old cottage hospital to our new modern building. One month later, the daily census had risen to 45.

The new hospital was originally planned to accommodate 42 patients, and this planning was based on exhaustive research as to probable use and expected community growth. However, immediate demand for more beds necessitated converting two beautiful solariums into four-bed units. Even with the increased bed complement, now 50, the daily census continues to run high. We feel, with pardonable pride, that the high daily census is due to the fact that the community likes our accommodations so much that our figures of expected use were wrong only because our hospital now offers much more than we anticipated.

Miss Stein is administrator, Webster District Hospital, Webster, Mass.

Our experience in the new hospital indicates that the careful architectural planning included sound ideas for a smooth running operation. These sound ideas were translated into positive action and the results have been satisfactory both to patients and our employes.

The services used by all classifications of patients, namely, the x-ray and laboratory departments, are conveniently located on the first floor. The accident room is adjacent to the ambulance entrance—a location that is not only convenient but timesaving.

The elevator, being situated in the center of the building, is extremely convenient for patients and visitors, and especially for the handling of linens, since the laundry is located directly opposite the elevator on the first floor, and the linen supply closet is located next to the elevator on the second floor.

Our patient accommodations are on the second floor, as are the operating suite and the delivery suite. These latter are in a separate soundproof wing.

Private rooms, semiprivate rooms and wards (which are only four-bed units) are all painted in soft, appealing pastel tints. The draw draperies over large picture windows are of neutral color. We feel this combination of décor makes for a relaxed and pleasant atmosphere. The picture windows by themselves allow the patients a view of the landscape which, in the spot where we are located, is a breathtaking sight at all seasons.

The hospital, as a result of careful planning by the building committee, representing the governing board, and by the architects, combines functional, efficient operation with beauty.

It is the pride of the community as well as the medical staff and personnel.

The hospital's autopsy room is located on the ground floor, only a short distance away from the elevator door in the service lobby. The room is also near receiving platform.

These students, in training to become surgical technical aides, listen attentively as Miss Ginsberg, using a heart model, demonstrates and describes the circulation of blood through the human heart. Training period lasts five weeks.

Aides Answer the Call for Help in Surgery

How the surgical aide training program prepares lay persons to give valuable assistance in the operating room under the direction of the surgical nursing staff

FRANCES GINSBERG, R.N.

ALL over the country professional nurses, even though they have had basic operating room nursing preparation, ask: "May I be a trainee in your course instead of a student instructor?" Administrators want to know: "When the next course is given can you teach more nurses to conduct these programs?" Surgeons ask: "Will you train three more technicians like our present ones?"

These questions would certainly indicate that there is general agreement in hospital circles that the surgical technical aide is here to stay. This conclusion was reached following critical evaluation of their contributions over a five-year demonstration period.

In many hospitals, surgical technical aides, more commonly called surgical technicians, are fulfilling vital rôles augmenting nursing service work loads within specialized departments. For several years, selected lay people have been trained to perform specific functions in an effort to relieve professional nurses of many tasks that could be safely accomplished by individuals of lesser skill and more limited background.

Frances Ginsberg has been a member of the staff of the Bingham Associates Program since 1951, serving as operating room nurse consultant. She is a graduate of Beth Israel Hospital School of Nursing, Boston, and holds both a bachelor's and a master's degree in nursing education from Boston University. She has been an instructor at the Yale University School of Nursing, and also has taught at Boston College and Boston University schools of nursing. During World War II, she served in the army nurse corps in the Southwest Pacific area.

The Bingham Associates Program, with headquarters at the New England Medical Center's New England Center Hospital in Boston, has pioneered in the venture to provide an annual planned and organized course of instruction for selected lay people who, following the experience, were equipped to function intelligently under the direct and continuous supervision of professional nurses in the areas of operating room, central service, delivery room and accident room. In keeping with its philosophy to improve medical care to patients within affiliated hospitals in Maine and western Massachusetts, the Bingham Program, under the leadership of Dr. Samuel B. Proger, president, set out to do something constructive about the acute shortage of trained personnel within its member hospitals.

Following completion of my research study, I was invited to implement my recommendations which were designed to alleviate staffing problems in selected hospitals. In 1952 I conducted a pilot study of this project at the Cooley Dickinson

Above: Trainees use petri dishes and throat cultures taken by hospital's laboratory technician to illustrate bacteriological principles in a "live" fashion.

Above: In studying care, preparation and processing of goods, students learn how to fold supplies to be sterilized and the technics of validating their sterility.

Hospital, Northampton, Mass., where the first five-week course of instruction was offered to four trainees (selected lay people). Since the Bingham Program is predicated on the concepts of regionalization, these principles were used in the pilot study. With the Cooley Dickinson Hospital serving as the educational base, other hospital administrators were invited to cooperate by sending selected candidates to the base school for instruction. An instructor-student ratio of one to four was considered optimum. Following the program, the trainees, armed with a certificate and new name pin, returned to their sponsoring hospitals to implement their new learning as well as to fulfill their moral obligation to serve in the hospital for at least one year. Follow-up studies were done to determine the effectiveness of the pilot study. It was soon apparent that interpretation of the course to each hospital's sustaining personnel was necessary in order that they could understand the increased potential of their surgical technical aides.

Shortly thereafter, the American Hospital Association expressed an interest in the pilot study. Through its operating room institutes conducted throughout the country, it was ascertained that a need existed for a guide to be used in the training of such personnel in other hospitals. With the development of a committee to study and work on this problem, in 1954 the "Surgical Technical Aide, Instructors' Manual" was published. The manual is widely used as a guide for the training of surgical technical aides, as well as for content material included in nursing students' basic aseptic technic courses.

In the planning for the program in 1953, the original course outline was modified and improved. It was felt that an additional contribution could be made if interested professional nurses could participate in the course as student instructors. Outlining a course of action, we listed the following experiences for the nurses during the five-week program: Audit all classes; prepare lesson plans; do practice teaching under supervision; formulate examination questions; supervise clinical experience of trainees; hold conferences with trainees and with the director of the program; plan for improvement of total experience.

Since this idea was conceived, 10 nurses have participated as student instructors and seven have been successful in conducting similar programs in their home environments. So enthusiastic was the response from the first three nurses that when Russell Nye, administrator of Northwestern Hospital, Minneapolis, offered to subsidize a workshop program designed specifically to teach nurses how to teach nonprofessional personnel, his request was honored with equal enthusiasm. With the proposed surgical technical aide manual used as a text, a two-week workshop was conducted for 53 nurses from the greater midwestern area.

In the workshop through group discussions, subgroup projects, lectures and rôle-play methods, we attempted to share basic technics of teaching as well as to demonstrate the type of content material which should be included in a trainee program. Although no formal follow-up study was done, it has been learned that a large number of the registrants are now conducting technician programs in their home hospitals. A similar workshop was conducted at Boston University School of Nursing during the summer of 1954.

The selection of a hospital to be used as the base school for the trainees' experience we felt was of critical importance. Careful evaluation was necessary regarding the adequacy not only of the physical environment, but also of the members who make up its staff. It was considered mandatory that the resource used be of a caliber which would be conducive to the success of such a venture. This we found at the Cooley Dickinson Hospital and at the Thayer Hospital, Waterville, Maine, where the last four courses have been conducted. The interest, cooperation and enthusiasm of the Thayer Hospital administrative, nursing, medical and paramedical staffs reflect credit on the hospital and the community of which it is a part.

Each year revisions and improvements have been made in the trainee program. As more people became involved with the plans, new ideas and

suggestions enriched the basic structure. During 1957, 14 trainees and two nurse assistant instructors were selected. This group represented nine different hospitals, eight from Maine and one from western Massachusetts. The five-week course included 120 hours of formal instruction and 80 hours of supervised practice. The content material comprised hospital ethics, anatomy, physiology, bacteriology, operating room technics, principles of asepsis, care, maintenance and preparation of supplies, and principles of obstetrics. Supervised practice was provided for in operating room technics as scrub assistant, circulating assistant, and housekeeping duties. Supervised practice was also given in central service procedures and delivery room technics. Classes were held concurrently with the clinical experience, and time was provided for practice of new skills.

During the first few days of the program, we endeavored to help the trainees adjust to their new environment as well as to each other. To many this was a frightening albeit exciting experience. Despite the magnitude of our program, we had to learn to "make haste slowly," and this we accomplished by means of a carefully planned orientation program. Time was taken to help develop sound perspective by sharing with the trainees the thinking and attitudes of the many people who make up the hospital team. Medical ethics were integrated into most classes, thereby reinforcing the trainees' responsibilities as members of the hospital family.

Beginning with the study of the normal human body, we discussed the classification and characteristics of living matter and then proceeded to a study of the systems of the body. Since it was recognized that nearly 85 per cent of learning is achieved through visual perception, quantities of visual-aid materials were used. For instance, in teaching the circulatory system, we used charts, blackboard diagrams, and the heart model as adjuncts. In the teaching of any subject we constantly remembered two important basic principles: Begin with the known, then proceed to the unknown; begin with the simple, then proceed to the complex. In building the unit on principles of bacteriology, an understanding of which is prerequisite to the safe handling of sterile goods and of any sterilization process, we discussed how the trainees used these principles in their daily living, *i.e.* washing hands before eating, bathing, use of deodorants, brushing teeth, shampooing hair. Starting with terms like "germs" and "bugs," we later changed this vocabulary to words like "bacteria," "microbes," and "microorganisms" and the trainees learned to use them with ease.

Above: Nurse Joan Abbott (r.) of Eastern Maine General Hospital, Bangor, applies lamp-black to a trainee's hands while second trainee begins scrubbing.

Above: Laboratory technician discusses fixation of surgical specimens; students follow course of specimens from time of removal to pathologist's last analysis.

Since we were verbalizing that which cannot be seen, with the assistance of the laboratory personnel we tried to make the subject "live" by having trainees cough and talk into petri dishes containing blood agar. Their throats were cultured and swabbed on a blood plate. The trainee sealed his own dish and placed it into an incubator after it was properly labeled with his name. The next day, each trainee eagerly examined his plate macroscopically and many protested that someone must have opened their dish! Later, a laboratory technician made slides of the different colonies of organisms and the trainees examined them microscopically. Although time consuming, we felt that this was effective teaching. Through these methods, the trainees learned the importance of proper masking; the reasons for frequent changes of masks; the significant differences in the number of colonies on a blood plate when one coughs and/or talks, as compared with a blood plate exposed to quiet normal breathing.

Medical terminology was perhaps the most difficult section to teach since the trainees had little, if any, frame of reference in this area. Mimeographed lists of prefixes and suffixes in addition to a glossary of terms were helpful. These lists had to be learned, and for some students it was difficult. They did, however, learn to associate the appropriate word with the particular organ or organs. In a relatively short time, they became proficient with medical terms and could easily interpret an operative schedule meaningfully.

The care, preparation and processing of goods included not only the folding of supplies to be sterilized, but also the technics of validating

SURGICAL AIDES LEARN THESE MEDICAL TERMS*

GLOSSARY

Aerobic. Lives only in the presence of oxygen.

Anaerobic. Micro-organism which thrives best or lives only without the presence of oxygen.

Anatomy. The science of the structure of the animal body and the relation of its parts.

Anesthesia. Partial or complete loss of sensation with or without loss of consciousness as a result of the administration of a drug or gas or as a result of disease or injury.

Antisepsis. The prevention of sepsis by the destruction of micro-organisms.

Arthrology. The study of the joints.

Asepsis. Absence of septic matter or freedom from infection.

Aseptic Technique. The maintaining of a sterile area or areas.

Bacteria. Minute, one-celled organisms which multiply by dividing in one, two or three directions.

Coagulation. The process of changing into a clot.

Commensalism. Pertaining to a non-parasitic organism living on or within one another.

Contamination. Soiling or making inferior.

Dermatology. Study of skin and skin diseases.

Disinfection. The act or process of destroying pathogenic germs or agents.

Endocrinology. The study of internal secretions.

Germicide. A substance that destroys germs.

Gynecology. The study of diseases of the female. Especially pertaining to the genital, urinary and rectal organs.

Micro-Organisms. Minute living bodies not perceptible to the naked eye.

Myology. The study of the muscles.

Neurology. Branch of medicine that deals with the nervous system and its diseases.

Nonpathogenic Organism. One that does not produce disease.

Obstetrics. That branch of surgery which deals with the management of pregnancy and labor.

Ophthalmology. The study of the eye and its diseases.

Orthopedics. Branch of surgery which deals with the correction of deformities and the treatment of chronic diseases of the joints and spine.

Osteology. The study of the bones.

Parasitism. Condition caused by organisms that live within, upon or at the expense of another organism known as the host.

Pathogenic Organism. One that produces disease.

Pathology. Study of the nature and causes of disease.

Pediatrics. Branch of medicine which treats the child, its development, care and the diseases of children and their treatment.

Physiology. The science of the functions of cells, tissues and organs of the living organism.

Proctology. Phase of medicine dealing with and treatment of diseases of the rectum and anus.

Psychiatry. Branch of medicine which deals with mental disorders.

Septic. Produced by or due to putrefaction.

Splanchnology. Study of the viscera.

Sterile. Free of all organisms.

Sterilization. Act or process of destroying all micro-organisms on a substance by exposure to chemical or physical agents.

Symbiosis. The association of two diverse, nonparasitic organisms dependent upon each other for existence.

Unsterile. An area which has not been freed of micro-organisms.

Urology. The department of medicine which has to do with urine and the urinary tract.

PREFIXES

Adeno. Pertaining to a gland.
Arthro. Pertaining to joints.
Chole. Pertaining to bile.
Cholecyst. Pertaining to the gall bladder.
Colpo. Pertaining to the vagina.
Colo. Pertaining to the large bowel.
Cranio. Pertaining to the cranium.
Cysto. Pertaining to the urinary bladder.
Entero. Pertaining to the intestine.
Gastro. Relating to the stomach.
Hydro. Denoting relation to water.
Mast. Signifying breast.
Nephro. Pertaining to the kidneys.
Oophoro. Pertaining to the ovaries.
Orchio. Pertaining to the testicles.
Osteo. Meaning bone.
Pneumo. Pertaining to the lungs.
Procto. Pertaining to the anus.
Salpingo. Relating to the Fallopian tubes.
Teno. Denoting tendon.
Thoraco. Pertaining to chest or chest wall.
Cardio. Pertaining to the heart.

SUFFIXES

-cele. Denoting hernia of.
-ectomy. Excision of.
-graphy. Pertaining to that which writes or describes.
-itis. Signifying inflammation.
-lysis. Indicating a loosening.
-ology. Pertaining to the science of.
-orrhaphy. Repair or sewing of.
-oscopy. Inspection, looking into.
-ostomy. Creation of an opening.
-otomy. Incision into.
-pexy. Fixation of.
-plasty. Repair of.

*Reprinted by permission from "Surgical Technical Aide: Instructor's Manual," published by the American Hospital Association.

their sterility. We taught the methods used in the Thayer Hospital but explained that other methods may be followed in other hospitals. Throughout the program stress was put on the basic principles that underlie any method.

Through the lecture method of instruction, principles of hand-scrubbing were carefully defined. Charts and blackboard diagrams were used to show that skin cannot be sterilized. Emphasis was placed on the importance of an "anatomical scrub," and the need for the technic to be completed in a planned, scientific manner. Fingernails were cut short and fingers were likened to cubes having four sides rather than just a front and back. A time limit for a hand-scrub was described as irrelevant since conscientious attention to the details of the technic was the important consideration.

Following the class, the group entered the scrub-up area where each trainee, assisted by a nurse instructor, performed the familiar lamp-black demonstration while blindfolded. It is gratifying to note that although a few trainees scrubbed as long as 25 minutes, not one of the 14 had any residual lamp-black on his hands following the demonstration. With this type of indoctrination, it was felt that these individuals could be considered safe, conscientious scrub assistants.

In the "Care of Pathological Specimens," we felt it was important to teach the ethical, moral and legal implications of their care, as well as the methods of collecting specimens, fixatives used, and records to be completed. Dr. Irving I. Goodof, Thayer Hospital pathologist, was most generous with his time in sharing with the group the medical point of view. To understand the complete procedure, each trainee followed the course of specimens from the time of removal from the body, placing into fixative, completing records accurately, delivery to the laboratory, the pathologist's gross examination, preparation of sections for the tissue processing machine, preparation of paraffin blocks, slicing of blocks with microtome blade, preparation of slides, and microscopic analysis by the pathologist. With this type of instruction, we felt that the trainee could efficiently carry out any hospital policy regarding surgical specimens.

Since we felt that one learns by doing, each trainee was taught how to handle plaster of paris in order to assist with the application of casts. Factors concerned with the support of an extremity, protection of bony prominences, maintaining good alignment were taught the group by a

Above, left: Mrs. C. Prentiss, graduate aide, teaches technic of handling plaster of paris. Above, right: Nurse Louise Sessler of Franklin County Public Hospital, Greenfield, Mass., demonstrates use of electro-cautery unit on piece of beefsteak.

surgical technical aide who was a student of our program in 1953. It was a motivating experience for the trainees to see other surgical technical aides in action.

An electro-cautery unit can be found in most hospitals. Since each of its parts is important, we considered it effective to demonstrate its use by cutting and coagulating a piece of meat. Although it was acknowledged that the trainees would not be in a position to use the machine during an operation, we felt that they would be given the responsibility to ensure the proper connections of each part. Following the demonstration, each trainee repeated the demonstration. In this manner, the ground, electrodes, points, foot switch, and other parts came to have more meaning.

During the experience, each trainee scrubbed and circulated for an average of 20 surgical procedures of both the major and minor type. We know, and, more important, they know that they are *not* independent practitioners. They realize that they have been trained in the basic concepts vital to working in the areas of operating room, central service, delivery room, and accident room. They acknowledge that there is a great deal more they can learn in their own hospitals. They realize their rôle in relation to professional nurses, doctors and patients. They know their functions as well as their limitations.

During the program and when it was completed, the trainees knew that they were wanted and that they could make a valuable contribution working under the direct and continuous supervision of professional nurses. In their home hospitals the trainees have perpetuated these feelings which may, in part, explain the reason for the extremely limited staff turnover within this group.

Since 1952, 47 trainees have completed the program. Of this group nine have left this work for the following reasons: One was considered unfit; two went to work in small industrial medical clinics; one left because of illness; two left for marriage and family; one entered the army, and two went into other hospital work.

In summarizing some of the important aspects of our program, we would make the following recommendations:

1. Candidates preferably should be high school graduates who are sincerely interested in this type of work. Of the 47 lay students we have had, 88 per cent were high school graduates. All of them had had experience in hospitals as nurse's aides, maids or orderlies for a period of not less than three months. The selection of candidates was delegated to the respective hospital administrative staff members, who were required to retain their candidates on the payroll of the "home" hospital during the five-week experience.

2. The institution selected as the central school should have adequate physical facilities and the entire hospital staff should be in accord with the program.

3. A well prepared nurse who is interested in teaching should coordinate the program. Sufficient time should be provided for teaching and the vast resources of the hospital should be utilized. The instructor must use a variety of teaching methods to make subjects "live." Finally, she must recognize individual differences in the trainees.

4. After the aides have been trained, in order that they can function most effectively, the ratio of one surgical technical aide to each professional operating room nurse on the sustaining staff should not be exceeded.

Graduates of this program serve as scrub assistants and circulating assistants; they prepare and sterilize materials and equipment in operating rooms and central service departments; they assist in labor and delivery rooms and in accident rooms. Their functions differ in various hospitals, depending primarily upon the philosophy of the institution. The demonstrated competence of the surgical technical aides also influences their function. The evaluation of their worth in the hospitals that now employ them shows that these people are extending an invaluable service to the nursing department.

In hospital schools of nursing, surgical technical aides have made it possible for basic nursing students in an operating room to enjoy a learning experience. Exploitation of students becomes unnecessary where there is adequate staffing to maintain the work load. Nursing students' experience has become more selective and more appropriately based on their educational needs.

The importance of a well trained staff of professional nurses in an operating room cannot be overemphasized. As surgical technology makes even greater advances, each nurse must be equipped to understand and to interpret new technics and skills to the people with whom she works. As a professional person she must be a leader, teacher, coordinator, supervisor and counselor. In her efforts to try to be all these things to all people, she needs help. The development of surgical technical aides may not be the entire answer to the nursing shortage, but our experience in a number of hospitals leads us to conclude that well trained surgical technical aides are making invaluable contributions to nursing service.

Volunteers Give Service No Money Can Buy

Cherry-uniformed volunteers brighten and stimulate the whole hospital because they lift the burden of extraneous chores from professional workers, but the chief beneficiaries of their work are the patients

PAUL W. KEARNEY

AT 8:30 one morning a badly hurt accident victim was rushed by police to the hospital in suburban Englewood, N.J. While doctors and nurses were working on the victim and police were notifying his wife, an emergency room clerk was dialing the Courtesy Desk in the lobby: "A Mr. Howard Blank has just been brought into Emergency. His wife will be here shortly. Keep an eye out for her. Doctor says she can see him briefly."

Fifteen minutes later, when a frantic housewife pushed through the door, another housewife in a cherry-colored coat was there to greet her by name and murmur a compassionate word of sympathy and hope. Relieving her of coat and handbag, this unexpected friend took her to Emergency to see her unconscious husband and speak to the doctor, then led her back to a comfortable chair in the attractive foyer. Only then did the inevitable admissions card appear with its tedious questions to be answered. Then a cup of tea was brought from the hospitality shop. After which some phone calls were made to the victim's father, his boss and others, with the lady in pink relaying the messages, making arrangements for picking up the children after school, et cetera.

A simple story, yet revealing. In any of the four metropolitan hospitals where I've been a patient six times in six years, the handling of the accident victim would certainly be as good; but unless the psychological victim of this accident—his wife—fainted or went into hysterics, the most she could hope for would be the stainless steel efficiency of those properly concerned more with the ill than the well. This kind of volunteer assistance is something new in American hospitals, and the banner which establishes the distinction is that cherry-red uniform, worn by volunteer workers in the Women's Hospital Auxiliary, a six-year-old national organization sponsored by the American Hospital Association.

My first introduction to this zealous group was at the Phelps Memorial Hospital, North Tarrytown, N.Y., where my wife and I went to visit a friend. The atmosphere was as different from an old-style hospital as noon is from twilight, and this was due not so much to the charm of the décor as to the refreshingly cheerful attitude of the personnel. Most conspicuous were the cherry pinafores

Volunteers at Long Beach Memorial Hospital, Long Beach, N.Y., are given an eight-weeks' course of training. Here they learn to change linen while patient remains in bed.

One place where volunteers are particularly valuable is in the central supply room. In the foreground volunteer sorts rubber gloves; at rear, another unloads the autoclave.

circulating on such errands as greeting visitors at the desk, arranging incoming flowers for patients, waiting on customers in the gift shop, or serving coffee and sandwiches in the hospitality shop. A patient arrived to be checked in and a young matron grabbed his bag with the alacrity of a hotel bellhop, steered him to the information desk, then headed with him toward the elevator.

The cherry-uniformed people are most accurately defined as "professional lay workers"—a contradiction in terms. They give skilled, trained talent without pay on a strict time-clock schedule, thus sharing a professional status, its obligations and responsibilities, with the salaried staff which they augment but never replace. Their influence brightens and stimulates the entire institution because their willing hands lift the burden of extraneous chores from nurses, technicians and interns, leaving these specialists freer to concentrate on the jobs only they can do. But the chief beneficiaries are the patients and their visitors.

The Phelps Memorial Auxiliary boasts about 1000 active members, one-third of whom in 1957 gave 41,350.5 hours of time in the hospital. Their work was coordinated and channeled through the office of a paid director of volunteers who works with the individual members, the administrator, and the hospital board, thus eliminating duplication, overlapping or waste effort. With an average of two paid employes per patient, even a relatively small suburban hospital like Phelps Memorial has 100 different specialized jobs.

Hence, when its auxiliary was being organized, the first question was, which of these jobs could use outside help; the second, what else could be done that would be useful? A list shaped up as follows:

1. Surgical dressings and instrument care.
2. Coffee shop and gift shop.
3. Baby photos.
4. Floor clerks.
5. Nurse's aides.
6. Information desk.
7. X-ray department.
8. Speech center.
9. General clerical work.
10. Babies' alumni service.
11. Patients' library.
12. Flower displays.
13. Arrangement of flowers for patients.
14. Conducted tours of hospital.

The visitor may see the women working in categories as Nos. 2, 6, 11, 12, 13 and 14 and be thoroughly impressed. But neither visitor nor patient can know of the mountain of paper work which builds up in a hospital; the volume of typing, indexing, filing and reference work to be done daily; the endless amount of sewing, packaging, folding and bandage rolling that goes on behind the scenes. Similarly, in the pharmacy, the linen room (issuing 12 to 15 pounds of linen daily per patient), the laboratories, central supply, the store rooms, the purchasing office (buying 3000 different items), the record rooms, the blood bank, and the diet kitchens, the trained volunteer can pitch in to level off the peak work loads without swelling the overhead. Small wonder, then, that at Phelps Memorial the monthly force of auxiliary workers regularly exceeds the size of the paid staff.

The quality, the volume and, above all, the continuity of hospital auxiliary work—shared by Protestant and Catholic, Jew and Gentile, black and white—is typical of a striking new trend in community service that is reaching right across the country. Volunteers have, of course, done valuable

(*Continued on Page 79*)

Even the Best Volunteers Need Good Training

There is no substitute for a nurse or other professional staff member in patient care, but there is badly needed and much appreciated assistance to be obtained from the volunteer if she has the right training and supervision

WILLIAM A. KOZMA

ONE of the biggest burdens of the average hospital executive these days is personnel shortage. This problem is common to large and small hospitals alike, but is perhaps more acutely felt in the small institution, where the loss of even one employe in any department can be a substantial percentage of the total staff. A partial solution to shortages of help has, in many instances, been the hospital auxiliary. The primary purpose of this organization is to render assistance to the hospital in ways approved by the governing board and the administrator. Possibly the greatest satisfaction the auxiliary member derives from her hospital experience is that which comes from personal service, particularly her direct contact with patients and visitors. If the hospital will train auxiliaries, use them, and reward them for their efforts, the return will be most gratifying.

Training programs should be well organized and conducted on a formal basis. Our training program at Long Beach Memorial Hospital, Long Beach, N.Y., runs eight weeks, covering 20 hours of instruction and demonstration. Volunteers meet each Monday from 10 a.m. to 12:30 p.m. We have purposely extended the program in this manner to weed out those who cannot maintain interest over a long period. The schedule of classwork is as follows:

First week: Introduction to the hospital and the training program. Educational tour of hospital and explanation of organization and functions of departments. Responsibility of volunteer to hospital and patient.

Second week: Introduction to the patient's needs. Answering signals. What can be done for patient with and without checking with nurse, *i.e.* preparing and serving fresh drinking

An administrator who appreciates the work of the auxiliaries is William A. Kozma, who believes that volunteers are especially valuable to the small hospital. Mr. Kozma has been administrator of Long Beach Memorial Hospital, Long Beach, N.Y., for the last five years, and was formerly assistant director of Southside Hospital, Bay Shore, N.Y. He received his master's degree in hospital administration from Columbia University.

water, assisting with trays, feeding the patient, and freshening up flowers.

Third week: Assisting the patient. Escorting patient from admitting office. Use of the wheel chair; assisting with wheeled stretchers. Medications, use of ice bags, hot water bags, the back rub. "Do's and Don'ts."

Fourth and fifth weeks: Bed-making and care of patient in bed at home and in hospital. Demonstration and application.

Sixth and seventh weeks: First aid and safety program.

Eighth week: Review and examination.

We consider the examination an extremely important part of our training. Mere physical attendance for prescribed classes is insufficient. To turn a poorly trained volunteer loose on a nursing floor is to add an extra burden to the nursing staff, instead of alleviating its already heavy duties.

The program is directed by the nursing department and a registered nurse is assigned to do the teaching. Selection of the nurse is important; she must be one who shows evidence of appreciating the volunteer service but who does not tend to become overly familiar with the volunteers.

All of our pink ladies, as they are appropriately called because of their pink uniforms, take the basic nurse's aide course—even if they have indicated a preference for other work. We have found this procedure advantageous for many reasons. The volunteer must receive from the program enough information to make her more valuable to her family in time of illness. Certainly, with a serious nurse shortage there will come a time when some ailments must be treated at home to prevent overtaxing limited staffs.

In addition, it has been found that many volunteers think they cannot work around sick people; however, once in the hospital in some other type of work many change their minds. If they have taken the nurse's aide course, it is simple to shift them about. Also, the largest number of volunteers is used in this category and the job of a nurse's aide requires the most formal training; by training all volunteers in the same way we develop a large reservoir of aides to call on when necessary. Upon completion of the course we try to place the women in the category they prefer. Their first assignments are under close supervision by an experienced pink lady.

In placing the volunteers in jobs it is most important that enough work be available. The main thing to remember is that volunteers love to be kept busy. This is not too difficult unless insufficient time was spent in preparing the hospital staff for the coming of volunteer assistance, or unless the volunteer service is poorly organized. Once the hospital staff members realize that casual intermittent offers of help have been organized into definite action that can be depended upon, they will accept this supplementary help with gratitude and will help increase the scope of volunteer activities.

In working on the floors and in other areas one finds volunteers to be excellent public relations aides. In many instances they will know the patients and can make them more easily understand necessary rules and procedures. Unfortunately, some hospital "regulars" are too close to the picture to understand what goes on in the minds of those who enter. They fail to recognize that these people are fearful, worried, usually in pain. But the layman remembers and, blessed with the proper personality, practices his own brand of therapy. The very presence of the volunteers indicates the hospital's desire to supplement the staff for the patient's benefit. The little extras that busy employes cannot fit into their work load can easily be accomplished by the pink ladies to the patient's satisfaction.

At our hospital we use pink ladies as nurse's aides, receptionists, clerks in the record room and x-ray department, central supply aides, and, in addition, they operate a patient library and gift cart service. The duties assigned are typical nonprofessional activities. In addition to invaluable assistance rendered the floor nurse we found the next most important job that of central supply aide. Volunteers assigned here are trained to clean, prepare and package syringes for autoclaving; sort, wash and powder gloves, and do other routine jobs assigned under the supervision of the nurse in charge.

We also have discovered laboratory technicians, medical secretaries, typists, and so on among our pink ladies, who have on occasion carried us through periods of critical shortages above and beyond the time they originally intended to give. There is a keen interest and loyalty developed among many of these women and they want to belong to the hospital family. It is always a pleasant sight to see the acceptance of each other by hospital staff members and volunteers as often evidenced in the dining room. We are fortunate to have come to the point where they mingle fully and are not two entities but one group working for the patient.

Finally, when the work is being accomplished, reward them for it. This can be done in many ways. A simple ceremony of awarding pins at a regular meeting—or a formal tea party—or a gala evening for the whole community to join in the reward ceremony are examples. It should be an annual event, something for the women to look forward to, and it should be a time of recognition and appreciation.

We make it a gala evening. The whole community is invited to an annual presentation of awards at a local school auditorium. The committee is selected from among the senior pink ladies, who make all the arrangements. It has been our experience that the more formal the program, the more the women appreciate their recognition and the greater is our recruitment of additional volunteers for forthcoming classes. Refreshments for pink ladies and the visitors follow the program.

Perhaps the original motivation in most volunteer programs is to obtain friends and good will ambassadors for the hospital. However, in time, the valuable assistance rendered by properly trained volunteers can aid immeasurably in bridging the gap between inadequate attention and better service to the patient.

In this article the examples used are from our experience at Long Beach Memorial. It is the result of trial and error to find the best combination to suit the needs and temperament of our community. There is today a fine program available to our women, and I know that our patient service has improved through their efforts despite periodic shortages of help. There is no substitute for a nurse in patient care, but there is assistance that is badly needed and appreciated. #

One of the duties customarily assigned to the volunteers is the operation of the patients' library and gift cart.

Volunteers are trained to assist in the x-ray department and to transport patients to and from the division. Duties assigned in this unit are typical nonprofessional activities.

Volunteers leave Long Beach Memorial Hospital after a training session. Classes meet each Monday from 10 a.m. to 12:30 p.m. Final session is a review and examination.

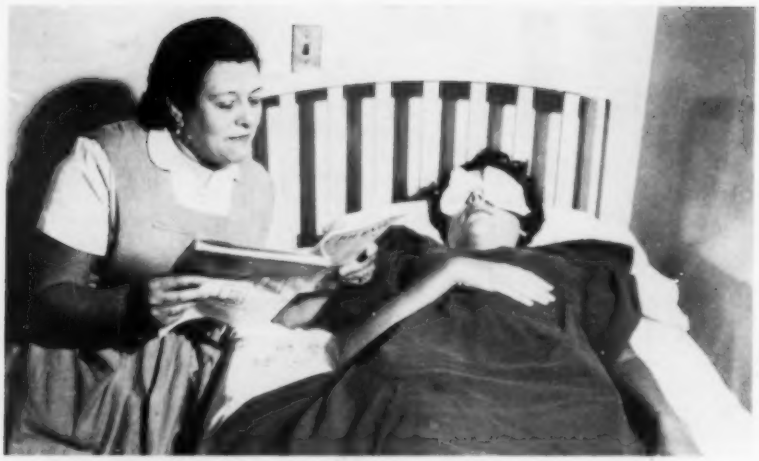
Volunteers Give Service No Money Can Buy

(*Continued From Page 77*)
hospital work since Civil War days; so this effort is "new" in application, in its diversity and its discipline, rather than in concept. The new thing about the W.H.A. effort is that for the first time there is a nationwide organization of volunteers, devoted exclusively to hospital needs, with a common set of standards and disciplines. Unlike the Gray Ladies of the Red Cross, the Junior Leaguers and other volunteer groups who give general service to hospitals, W.H.A. members are organized under the auspices of a specific hospital, responsible to its director.

Developed largely since World War II the American Hospital Association's auxiliary program is powered by busy housewives who have their own families and plenty of other things to do. Some arrive for work in Lincolns or Cadillacs, others by bus. The great leveler is the cherry-red uniform; the one thing everyone has in common is the steadfast urge to do something useful for the community hospital. "The surest way to discourage the auxiliaries into staying home," said one administrator, "is not to give them too much to do—but to give them too little."

We found this attitude repeated at the Greenwich Hospital, Greenwich, Conn., and the Englewood Hospital, Englewood, N.J., which serve comparable populations. The 245 bed Greenwich Hospital saw over 600 volunteers contribute 70,000 hours of work last year. An average 50 of them, ranging in age from 13 to 90, are on duty every day—whether the day is Christmas, New Year's or just another Thursday. And if you suspect that the 90 year-oldster is just an ornament, make note that last year she made over 200 puppets, glove-like dolls, which the child patients put on their hands and animate, with delight.

Among the outstanding features at the 270 bed Englewood Hospital is a special group of 20 night volunteers, and an exceedingly lively Junior brigade numbering approximately 180 members. The night workers are for



Reading to patients who are incapacitated by eye injuries or disease is another function of the women volunteers at Long Beach Memorial Hospital.

the most part business or professional women, with eight-hour-a-day jobs, who come to the hospital from 6:30 until 9 or 10 o'clock. The Juniors come in after school hours, on week ends, and during the summer when many regular volunteers go out of town. In an ordinary school month, 86 Juniors will give 660 hours of time.

In recent weeks my wife and I have looked at the same type of indefatigable volunteer service in North Carolina, Tennessee and Illinois. Duke Hospital, Durham, N.C., is a 660 bed institution with a problem all its own. As part of the University Medical Center, it caters to the "problem patients" of smaller community hospitals, and, with such a preponderance of strangers, the cold hand of institutionalism inevitably hovers. Hence the chief function of this auxiliary is to add the warm, sympathetic, good neighbor touch to an institution where virtually everybody is an outsider.

"The energies of the volunteers are precisely fitted to the hospital's needs," the administrator told me. "This does not include relieving nurses or technicians of their responsibilities—it is our job to provide sufficient paid personnel for that. But these dedicated women supply a service and an atmosphere which we cannot buy."

Two of the newer aspects of the auxiliary's work at Duke are the chaplain service and the psychiatric service. In the former, mature women of the proper temperament assist clergymen of various faiths in helping relatives or friends of the critically ill, often a heart-wrenching assignment. In the latter service, hand-picked volunteers with talents in music, clay modeling, finger painting, flower handling, etc., work with the mentally ill. Recently a woman physician who had been a psychiatric patient at Duke—and seemingly a hopeless one—wrote the hospital that the real turning point in her illness was provided by the volunteer whose patience and tact had induced her to try clay modeling.

At the Rockford Memorial Hospital, Rockford, Ill., of 240 beds, volunteers number 1060 members. About a third wear the cherry-colored uniforms, and are called Pink Ladies. Before they can begin to serve, they must complete eight hours of classroom work spread over four successive Monday evenings, then pass an examination covering 71 questions. Most in-hospital workers also take an annual refresher course. Many of Rockford Memorial's play ladies in pediatrics are school teachers, active or retired. And pediatrics is the only place in the hospital where volunteers help out directly with the nursing service.

At the 245 bed Holston Valley Community Hospital, Kingsport, Tenn., an auxiliary organized in 1952 now has 678 members, of whom 102 are high school girls. These Juniors wear a distinctive candy-striped pinafore now adopted by the American Hospital Association as official junior garb.

This hospital's special service is its Helping Hand Committee. Situated on route U.S. 11W which feeds tourists into the Great Smokies, Kingsport is well acquainted with traffic accident problems, many of which involve travelers far from home. Picture the predicament of a family when the father and mother both wind up in the hospital. Often they haven't brought enough money. What is happening to the children in the meantime? Who is going to notify distant relatives, take charge of the wrecked car, attend to the hundred and one details that arise?

Well, in Kingsport it is the members of the Helping Hand Committee who open their homes, their hearts—and their purses, if need be. In one recent year they provided lodging in their homes for 31 people for 225 days (relatives of hospitalized victims); served 46 meals to 10 others; arranged out-of-state transportation for nine; donated 50 pints of blood; performed countless errands, laundry and mending chores, child care, taxi service, even put up the money to get one stranded family of five to California.

About 1200 hospitals throughout the country boast a similar auxiliary service, while some 1800 other association member hospitals have volunteer units ready for recognition. The great majority of our hospitals, however—4000 of them—still do not have the invaluable help, the extra human touch, of the dedicated ladies in pink.

Puppets Brighten the Stay of Pediatric Patients

PEDIATRIC patients in Louisiana and Pennsylvania received "stay-brighteners" recently, from such varied sources as the women's auxiliary and the city fire department.

At Baton Rouge General Hospital, Baton Rouge, La., the women's auxiliary constructed "Cheery, the Puppet" to join the 2-to-10 year olds in the hospital. The hand puppet, dressed in a short gown and pointed cap of cherry red material, is given to each child on admission. He keeps the puppet throughout his hospital stay and then may take it home with him. The puppet, was sewn by the auxiliary under the direction of Mrs. T. Ellis Peak, president.

During Fire Prevention Week in Altoona, Pa., the fire department paid a visit to Mercy Hospital. Each child was presented with a red fire marshal's helmet, gift of the Hartford Fire Insurance Company, and a junior fire marshal's ring.

These gifts, however, caused a few anxious moments for Sister M. Adeline, floor supervisor, reported *Newsrama*, the hospital's publication. After bidding the fire department and insurance company officials good-by, she heard unusual noises from the floor. Hurrying to the section, she found all the children who could get out of their cribs on the floor—ready to "play fire." Fortunately, the bulletin commented, there actually was no fire, and all the children were safe. #

ABOUT PEOPLE

Administrators


Arthur G. Hennings

Arthur G. Hennings has been appointed director of the University of Texas Medical Branch Hospitals and professor of hospital administration at the university. Mr. Hennings is a member of the hospital consulting organization of James A. Hamilton Associates and assistant professor of hospital administration at the University of Minnesota, positions he has held for the last four years. Previously, he served in administrative posts at Butterworth Hospital, Grand Rapids, Mich., and Northwestern Hospital, Minneapolis. Mr. Hennings is a graduate of the University of Minnesota's course in hospital administration and a fellow of the American College of Hospital Administrators.

Eva M. Wallace, administrator of All Saints Episcopal Hospital, Fort Worth, Tex., since 1937, has retired from active administration. She will continue as consultant for the new 351 bed hospital now under construction. Miss Wallace is a fellow of the American College of Hospital Administrators and a past president and charter member of the Texas Hospital Association; she also is a past president and charter member of the Northwest Texas Hospital Association. She has held numerous committee chairmanships in various hospital organizations. Miss Wallace will be succeeded by **Bill L. Hamilton,** who was assistant administrator.

James D. Anderson has been appointed assistant director of Lutheran Deaconess Home and Hospital, Chicago. He previously was administrative assistant at Memorial Hospital, Elmhurst, Ill. Mr. Anderson is a graduate of Northwestern University's program in hospital administration.

Harry O. Humbert has been appointed to the newly created post of assistant vice president (financial) of Roosevelt Hospital, New York. Mr. Humbert joined the staff in May 1957 when he was appointed controller and assistant treasurer.

Harry Hochstadt has been named administrator of American Legion Hospital for Crippled Children, St. Petersburg, Fla., succeeding **E. A. Roberts,** who has retired.

Dr. Ellsworth R. Browneller has been appointed medical director of Jefferson Medical College Hospital, Philadelphia. He had been acting director since January 1957. Dr. Browneller received a master's degree in administrative medicine from Columbia University, and served a residency in administrative medicine at Henry Ford Hospital, Detroit.

Willis S. Thrash, assistant director of the University of Mississippi Hospital, Jackson, has been appointed administrator of South Highlands Infirmary, Birmingham, Ala. He will succeed **Joe Vance,** whose appointment as assistant executive director of Blue Cross-Blue Shield of Alabama was announced in the December issue of The Modern Hospital.

Lois A. Roscoe, administrator of Fort Hamilton Hospital, Hamilton, Ohio, for more than 19 years, has retired from active administration to become a consultant for the hospital. Miss Roscoe is a fellow of the American College of Hospital Administrators and has held various offices in state hospital organizations. She served as superintendent of Olean General Hospital, Olean, N.Y., for 10 years; during that time she became a charter member of the Western New York Hospital Council. Miss Roscoe will be succeeded at Fort Hamilton Hospital by **Gaston Herd,** who has been assistant administrator for several months. Mr. Herd is a graduate of the University of Minnesota's hospital administration course.

John B. McMillen has been named assistant administrator of St. Mary's Hospital, Enid, Okla. He has served as business manager since June 1956.


James L. Smith

James L. Smith has been appointed assistant to the dean for hospital administration at New York Medical College, Flower and Fifth Avenue Hospitals. Mr. Smith previously served as assistant general manager of Memorial Center for Cancer and Allied Diseases for five years. He succeeds **E. Ross Winckler,** who recently resigned after 10 years as administrator of Flower and Fifth Avenue Hospitals.

Mabel C. Prevost, director of the school of nursing and nursing service at Jefferson Medical College Hospital, Philadelphia, has been appointed administrative assistant. Previously Miss Prevost had served as educational director and assistant director of nursing service at Germantown Dispensary and Hospital, Philadelphia, and as assistant director of nursing at Jefferson Medical College Hospital

Edwin J. Klag, assistant manager of the Veterans Administration Center in Wichita, Kan., has been appointed manager, succeeding **Noel M. Jeffrey,** who has retired. Mr. Klag has been assistant manager since June 1949.

Leonard C. Small has been appointed administrative assistant at Duke Hospital, Durham, N.C., succeeding **John M. McBryde Jr.,** who resigned to accept a similar position at Good Samaritan Hospital, Lexington, Ky.

Thomas G. Peyton has been named the first administrator of McPherson Hospital, Durham, N.C. Mr. Peyton previously was director of the outpatient clinic at North Carolina Memorial Hospital, Chapel Hill, N.C.

V. Gray Herring Jr. has succeeded the late **J. R. McLeod** as administrator of Wayne County Hospital, Goldsboro, N.C.

Modesto C. Otero Jr. has been named administrator of Madison County Memorial Hospital, Madison, Fla., succeeding **Bert V. Culwell,** whose appointment as administrator of Cullman Hospital, Cullman, Ala., was reported in the January issue of The Modern Hospital.

Kenneth Dahl has been appointed administrator of General Hospital of Greater Miami, Inc., at Coral Gables, Fla.

Leslie J. Froman has been named administrator of William Crispe Hospital, Plainwell, Mich., succeeding **John Setsma Jr.,** who resigned.

Bernie Welch has been appointed assistant administrator of Morrell Memorial Hospital, Lakeland, Fla. Mr. Welch is a graduate of the hospital administration course at Duke University.

Robert G. Jeffries has been named assistant administrator of Abermarle Hospital, Elizabeth, N.C. Mr. Jeffries, a graduate of Georgia State College of Business Administration, served his administrative residency at Athens General Hospital, Athens, Ga.

(*Continued on Page* 150)

PROTOTYPE STUDY:

100 BED PROPRIETARY HOSPITAL

Continuing a new series of prototype studies of proprietary short-term general hospitals with up-to-date information on principal departments

LOUIS BLOCK, Dr. P.H.

Chief, Research Grants Branch
Division of Hospital and Medical Facilities
Public Health Service, Washington, D.C.

THIS is the fourth of a series of prototype studies on the proprietary short-term general hospital in the United States. Such hospitals, while they represent only 2.3 per cent of all hospital beds and 6.5 per cent of all beds in general short-term hospitals, do represent 15 per cent of all the hospitals in the United States and 20 per cent of all general short-term hospitals. Previous articles have considered the 25, 50 and 75 bed hospitals. Future articles will describe the facilities, their use, finances and personnel in 125, 150 and 15 bed proprietary hospitals. Comparisons between the proprietary and nonprofit hospital accompany each article except for the 15 bed hospital where no comparable figures are available.

PUBLIC RELATIONS

Frequency of Hospitals Using:	*Per Cent of Hospitals*
Booklet for patients	21
Booklet for employes	12
Regularly published house organ	6
Printed annual report	8
Patient opinion poll	22
Personnel opinion poll	8
Medical staff opinion poll	12
Community opinion poll	0
No polls	71

PURCHASING

A central purchasing department is to be found in 83 per cent of the 100 bed proprietary hospitals. Of those hospitals that have central purchasing, a full-time purchasing agent is employed in 25 per cent.

BED DISTRIBUTION

In most of these hospitals there is a specific bed assignment for special patient groups. Where more than 50 per cent of the hospitals within this size group make such an assignment they are usually considered as having specific bed assignments for purposes of this study. Where bed assignments occur in less than half of these hospitals, they are considered as unassigned. The following tabulation shows the specific or unassigned service groupings, the frequency with which they occur, and the average number of beds that are assigned to them:

Medical-surgical patient beds
- a. Frequency of occurrence ..... 7 in 10 hospitals
- b. Average number of beds assigned .. 72

Obstetrical patient beds
- a. Frequency of occurrence ..... 7 in 10 hospitals
- b. Average number of beds assigned .. 19

Pediatric patient beds
- a. Frequency of occurrence ..... 1 in 2 hospitals
- b. Average number of beds assigned .. 9

Isolation or contagious patient beds
- a. Frequency of occurrence ..... 1 in 8 hospitals
- b. Average number of beds assigned .. 7

Psychiatric patient beds
- a. Frequency of occurrence ..... 1 in 17 hospitals

Tuberculosis patient beds
- a. Frequency of occurrence ..... 1 in 40 hospitals

ACCOUNTING

Depreciation is calculated in 93 per cent of the hospitals, the depreciation being funded in 15 per cent. Twenty per cent of the hospitals operate under formal budgets, and 52 per cent use the American Hospital Association chart of accounts.

RELIGIOUS

Frequency of Hospitals With:	*Per Cent of Hospitals*
A chapel	0-1
A meditation or prayer room	5
An organized visiting clergy staff	35
A chaplain available	53
A full-time chaplain	1
A part-time chaplain	4
A chaplain on call only	48

SERVICES

Where services are provided in more than half of these hospitals they are considered as being available in terms of this study. Services that might be provided but are found to occur in less than 50 per cent of these facilities are considered as unavailable. Certain of these services may be provided through arrangements with other hospitals and sources. Such arrangements are not reflected in the frequencies shown:

Frequencies of Hospitals Offering:	*Per Cent of Hospitals*
Clinical laboratory	96
Basal metabolism apparatus	96
Electrocardiograph	93
Central sterile supply room	68
Blood bank	66
Electroencephalograph	14
Dental department	14
Hospital auxiliary	7
Medical record department	94
Operating rooms	95
Obstetrical delivery rooms	87
Medical staff library	60
Pharmacy	46
Physical therapy department	31
Postoperative recovery room	22
Occupational therapy department	6
X-ray diagnosis	98
X-ray therapy	39
Premature nursery	39
Radioactive isotope therapy department	9
Routine chest x-ray on admission	21
Social service department	3
Outpatient department	52
Patients' library	19
Cancer clinic	11
Rehabilitation department	2
Children's educational program	0
Mental hygiene clinic	0

PERSONNEL

The number of full-time personnel employed by the prototype 100 bed proprietary short-term general hospital is 130. The number of full-time personnel per 100 patients is 186, with the number of full-time employes per bed, 1.3, and the number of full-time employes per occupied bed, 1.9.

Only one in 25 of the 100 bed hospitals has an organized auxiliary. For those hospitals having an organized auxiliary, the average membership is 15, with the average number of auxiliary members working in the hospital numbering five. The number of persons other than hospital auxiliary contributing volunteer service is 13.

A graduate nursing staff numbering 30-34 is employed as follows: 1-2, or 5 per cent, in an administrative capacity; 3-4, or 11 per cent, as supervisors and assistants; 6-7, or 20 per cent, as head nurses and assistants; 15-16, or 48 per cent, as full-time general duty nurses; 5, or 16 per cent, as part-time general duty nurses. Nine nurses would be available for private duty.

The average number of other nursing personnel at the prototype hospital is: practical nurses, 18-19; attendants, 5; nurse's aides, 21; ward maids, 7, and orderlies, 6.

Where they are employed at all (see chart on this page), the 100 bed hospital has the following full-time personnel: pharmacists, 1; other medical record personnel, 2; dietitians, 1-2; medical social workers, 1.

Also, the proprietary 100 bed short-term general hospital will employ full-time help in the following categories: medical technologists (one registered, two not registered); x-ray technologists (one registered, one not registered); medical record librarians (one not registered); occupational therapists (one not registered), and physical therapists (0-1 registered and one not registered). One unregistered part-time medical technologist might also be employed.

MEDICAL STAFF

The frequency of hospitals having certain services and organizational relationships is as follows:

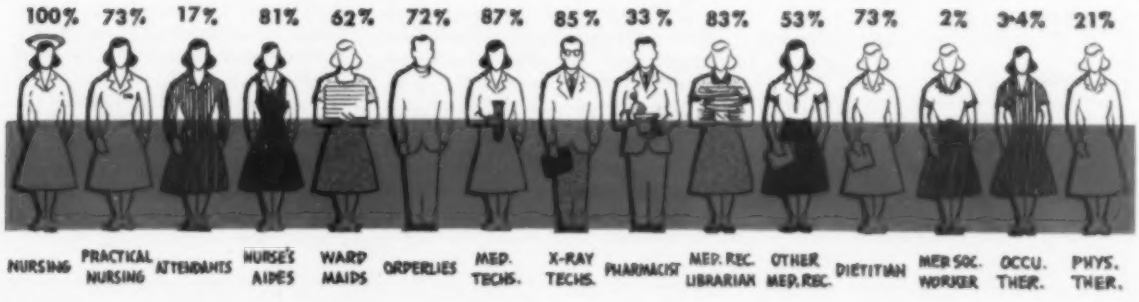
	Per Cent of Hospitals
Chief of staff	92
Chiefs of services	78
Written staff regulations	81
Regular staff meetings	90
Standing staff committees	76
Executive staff committee	65
Medical record committee	60
Credentials committee of staff	56
Tissue committee of staff	44
Education committee of staff	14
Pharmacy committee of staff	15
Dietary committee of staff	18
Nursing committee of staff	33
Psychiatrist on staff	47

Surgical restrictions are placed on the staff by 79 per cent of the hospitals. Nonstaff members are permitted to practice in 29 per cent of the hospitals.

Examining rooms for ambulatory patients of the medical staff are provided in 60 per cent of the hospitals; private physicians' offices in or on the hospital grounds are provided in 45 per cent of the hospitals, while x-ray facilities are available to private ambulatory patients of the staff in 91 per cent of the hospitals, and 89 per cent of the hospitals make laboratory services available to private ambulatory patients of the staff.

Forty-five per cent of the 100 bed proprietary hos-

PERCENTAGE OF 100 BED HOSPITALS HAVING THE FOLLOWING PERSONNEL



pitals have received accreditation by the Joint Commission on Accreditation of Hospitals.

The number of staff physician appointments averaged 88, including: active staff, 32; associate staff, 8; courtesy staff, 41; consultant staff, 6; honorary staff, 1.

The number of staff physician appointments per 100 beds averaged 88, divided as follows: active staff, 32; associate staff, 8; courtesy staff, 41; consultant staff, 6; honorary staff, 1.

Where 50 per cent or more of these hospitals had particular staff relationships or services, it was considered as being the normal practice in this study. Where less than 50 per cent of these hospitals had them, they are considered as not being normally available.

RADIOLOGY

Frequency of Hospitals Having:	*Per Cent of Hospitals*
Physician staff members specializing in radiology	74
a. Full-time	35
b. Part-time	38
X-ray facilities available to private ambulatory patients of physicians	91
Chest x-ray on admission	21

PHARMACY

Almost one in two of the 100 bed general proprietary hospitals operates a pharmacy. Of these, one in three has a full-time licensed pharmacist. Three in five of these hospitals have a drug formulary.

COMPARISON OF 100 BED PROPRIETARY GENERAL HOSPITAL

THE following indicates certain areas of similarity and difference between the 100 bed nonprofit general hospital and the 100 bed proprietary general hospital:

BED DISTRIBUTION

1. At least half of these hospitals in each control group make specific bed assignments for medical-surgical, obstetrical and pediatric patients. The proprietary hospital assigns a greater number of medical-surgical patient beds and a lesser number of obstetrical and pediatric patient beds.

UTILIZATION

1. The proprietary hospital shows a greater number of admissions, census and occupancy and a lesser newborn census and patient stay than does the nonprofit hospital.

2. In other areas such as births and patient days of care, both groups are similar.

SERVICES

1. This size hospital, in both control groups, usually provides a blood bank, central supply room, clinical laboratory, electrocardiograph, basal metabolism apparatus, medical library, medical record department, outpatient department, and x-ray diagnosis.

2. The nonprofit hospital, in addition to the foregoing, will have a hospital auxiliary, patient library, pharmacy and premature nursery.

FINANCIAL

1. Both total assets and plant assets are less in the proprietary hospital. Despite this the proportionate relationship of plant assets to total assets is the same in both groups.

2. Both total income and patient income and total expenses are greater in the proprietary hospital.

3. Although payroll expense is the same in both groups the per cent payroll of total expenses is less in the proprietary hospital.

PERSONNEL

1. The proprietary hospital has approximately the same total number of full-time personnel as the nonprofit hospital. However, the ratio per patient is less in the proprietary hospital.

2. The proprietary hospital is less likely to have an organized auxiliary.

3. The average number of volunteers contributing service to the hospital is less in the proprietary hospital.

4. Total graduate nursing personnel is less in the proprietary hospital. This is reflected in a lesser number of graduate general duty nurses, both full-time and part-time.

5. The proprietary hospital shows a greater number of private duty nurses and practical nurses and a similar number of attendants, ward maids, orderlies, medical technologists, x-ray technicians, medical record librarians, dietitians, medical social workers, and pharmacists, when they do have such personnel.

6. When such service is provided, the nonprofit hospital is more likely to have a registered full-time occupational therapist and a registered full-time physical therapist, whereas the proprietary hospital is more likely to have such full-time personnel other than registered.

MEDICAL STAFF

1. There is general similarity in the organization of the medical staff in both control groups as evidenced in committees established.

2. The proprietary hospital is more likely to have surgical restrictions on the staff and to provide service to private patients of the medical staff.

3. The nonprofit hospital is more likely to be accredited by the Joint Commission on Accreditation of Hospitals.

4. The proprietary hospital has a greater number of staff appointments.

NURSERY

1. The proprietary hospital has a lesser number of bassinets.

2. The nonprofit hospital is more likely to have special nurseries for premature infants.

3. There is similarity in both control groups in the provision of infant incubators and in the numbers provided.

ADMINISTRATOR

1. Although in both hospital groups the administrator is more likely to be a person who is other than a physician or a nurse, the proprietary hospital is more likely to have a physician as administrator than is the nonprofit hospital.

2. In the nonprofit hospital the administrator is more likely to be a graduate of a college course in hospital administration than is the administrator of the proprietary hospital.

3. In the proprietary hospital the administrator is more likely to be a man, while in the nonprofit hospital the administrator is equally as likely to be a woman as a man.

4. Administrative responsibility is

LAUNDRY

One in three of the hospitals studied operates its own laundry and processes all soiled linens. In those hospitals 5400 pounds of laundry are processed per week, and 280,000 pounds per year, averaging 11 pounds per patient day.

For those hospitals that do not operate their own laundry, two in three, 4400 pounds are processed per week, or a total of 230,000 pounds in a year, for an average of nine pounds per patient day.

OUTPATIENT DEPARTMENT

Annual number of outpatient visits	10,100
Annual number of emergency visits	2,300

NURSERY

The 100 bed proprietary hospital has 16-17 bassinets. Thirty per cent of these hospitals have special nurseries for premature infants, while 77 per cent have infant incubators. In those hospitals having them, there are three infant incubators.

Bead bracelets are used for identification in 83 per cent of the hospitals; tape bracelets are used in 12 per cent.

OPERATING ROOMS

Number of operating rooms	3
a. Major operating rooms	2
b. Minor operating rooms	1

(Continued on Page 86)

WITH THE 100 BED NONPROFIT GENERAL HOSPITAL

more frequently delegated to the night nursing supervisor in the proprietary hospital.

OPERATING ROOMS

1. It is most likely that the nonprofit hospital will have one more operating room.

LABORATORY

1. Although there is similarity in the frequency with which both groups have a physician staff member specializing in pathology, the proprietary hospital is more likely to have him on a full-time basis.

2. There is similarity in both groups in the frequency of these hospitals requiring urinalysis on all admissions, electrocardiogram on all admissions over 45 years of age, and preoperative coagulation on all tonsillectomies.

3. The nonprofit hospital is more likely to require a blood count on all admissions, serological examinations for syphilis on all adult admissions, and preoperative blood grouping on all surgical cases.

4. The proprietary hospital is more likely to require that all tissue removed at surgery be routinely examined by a pathologist, Rh grouping be made of all pregnancy cases, and postoperative urinalysis be made on all surgical cases.

RADIOLOGY

1. Although the nonprofit hospital of this size shows a greater frequency of physician staff members specializing in radiology, they are likely to have a greater portion of them on a part-time basis than is the proprietary hospital.

PHARMACY

1. The proprietary hospital shows a lesser proportion operating pharmacies. In those that do, they also show a lesser proportion employing a full-time pharmacist.

2. The frequency with which both groups have a drug formulary is the same.

OUTPATIENT DEPARTMENT

1. The proprietary hospital shows a greater number of outpatient and emergency visits.

MEDICAL RECORDS

1. Both hospitals have the same frequency with regard to microfilming medical records.

2. The nonprofit hospital is more likely to use Standard Nomenclature of Diseases and Operations.

DEATHS AND AUTOPSIES

1. Although the per cent of autopsies of deaths is the same in both groups, the proprietary hospital shows fewer numbers of deaths and autopsies.

ADMITTING

1. The proprietary hospital is less likely to routinely admit patients with special diagnoses.

ACCOUNTING

1. The proprietary hospital more frequently calculates depreciation, but funds it less frequently than does the nonprofit hospital.

2. The proprietary hospital less frequently operates under a formal budget and less frequently uses the American Hospital Association chart of accounts.

PURCHASING

1. Although the frequency with which the proprietary hospital has a central purchasing department is greater, the nonprofit hospital is more likely to have a full-time purchasing agent.

PUBLIC RELATIONS

1. The proprietary hospital is less likely to employ methods of obtaining opinions concerning the hospital than is the nonprofit hospital.

DIETARY

1. The proprietary hospital is more likely to provide a selective menu for all patients.

LAUNDRY

1. The proprietary hospital is less likely to operate its own laundry. When it does, the volume of work performed is less in the proprietary hospital than it is in the nonprofit hospital.

2. When laundry is done outside, the proprietary hospital shows a lesser amount in both total pounds and on a per patient day basis.

SAFETY

1. There is similarity in both groups in the frequency in which they have a written plan and hold regularly scheduled fire drills.

RELIGIOUS

1. The proprietary hospital is less likely to provide religious facilities such as a chapel, meditation or prayer room than is the nonprofit hospital.

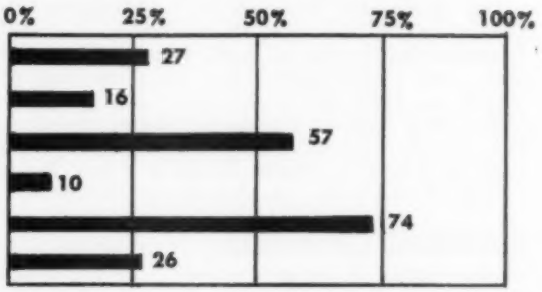
2. The same is true with regard to chaplain or visiting clergy.

AMBULANCE

1. The proprietary hospitals more frequently provide ambulance service. This is true in their use of private, nonhospital ambulances. They are less likely to operate their own ambulances.

BACKGROUND OF CHIEF ADMINISTRATIVE OFFICERS IN 100 BED HOSPITALS

Frequency of Hospitals:	*Per Cent of Hospitals*
Where chief administrative officer is a physician	27
Where chief administrative officer is a graduate nurse	16
Where chief administrative officer is other than a physician or a nurse	57
Where chief administrative officer is a graduate of a college course in hospital administration	10
Where chief administrative officer is a male	74
Where chief administrative officer is a female	26



ADMINISTRATOR

There is a full-time assistant administrator in 47 per cent of the 100 bed proprietary hospitals studied. Administrative responsibility is delegated to the night nursing supervisor in 73 per cent of the hospitals, while an administrative staff member is on duty at night in 21 per cent of the hospitals.

MEDICAL RECORDS

Only one in six of the 100 bed proprietary hospitals microfilms medical records. Four in five of the hospitals use the Standard Nomenclature of Diseases and Operations.

ADMITTING

Admitting records are duplicated by a typewriter in 61 per cent of the hospitals studied, by a mimeograph in 1 per cent, and by hand in 30 per cent of the 100 bed proprietary hospitals. None of the prototype hospitals uses liquid or gelatin or plate imprint duplicating methods.

The following percentage of the 100 bed proprietary hospitals routinely treat patients with the indicated diagnosis:

	Per Cent of Hospitals
Alcoholics	21
Cancer	76
Cardiac	93
Dermatologic	70
Drug addiction	6
Epileptic	19
Gynecologic	85
Isolation (contagion)	16
Medical	98
Mental deficient	3
Neurologic	45
Obstetric	89
Ophthalmic	69
Orthopedic	92
Otorhinolaryngologic	65
Poliomyelitis	8
Psychiatric	7
Surgical	98
Tuberculosis	6
Urologic	84
Venereal disease	18
Acutely ill	99
Chronically ill	64
Convalescent and rest	12
Geriatric	34
Industrial	76
Pediatric	84

SAFETY

An organized safety committee is to be found in 39 per cent of the hospitals studied. Written fire emergency and evacuation plans are found in 52 per cent of the hospitals, while regularly scheduled fire drills are held in 34 per cent. A written plan for mobilization of employes and medical staff is available in 35 per cent of the hospitals studied. Thirty-three per cent of these hospitals have integrated this written mobilization plan into the master community plan, and a representative of the hospital sits on the community disaster planning committee in 63 per cent of the cases.

LABORATORY

Frequency of Hospitals Having:	*Per Cent of Hospitals*
Physician staff members specializing in pathology	74
a. Full-time	31
b. Part-time	43
All tissue removed at surgery routinely examined by a pathologist	88
Urinalysis on all admissions	89
Blood count on all admissions	80
Serological examination for syphilis on all adult admissions	55
Electrocardiograph on all admissions over 45 years of age	1-2
Rh grouping on all pregnancy cases	60
Preoperative blood grouping on all surgical cases	38
Preoperative coagulation on all tonsillectomies	80
Postoperative urinalysis on all surgical cases	38
No tests without doctor's orders	11
Laboratory facilities available to private ambulatory patients of physicians	89

DEATHS AND AUTOPSIES

There are 82 deaths annually in the prototype hospital. These deaths make up 2.0-2.1 per cent of admissions. The number of annual autopsies performed in the prototype hospital is 16, being 20 per cent of the total number of deaths. Eight of the annual deaths are released to legal authorities, or 0.2 per cent of admissions.

AMBULANCE

Frequency of Hospitals Which:	*Per Cent of Hospitals*
Provide ambulance service	98
Operate own ambulance	1
Use city or publicly owned ambulances	4
Use private nonhospital ambulances	93

(Continued on Page 88)

From *Campbell's* ...

NOW IN THE 50-oz. SIZE!

3 GREAT NEW SOUPS

3 New Soups!

These are the same Campbell Soups that were just introduced to the public with a barrage of newspaper, magazine, radio and TV advertising. Cash in on the overwhelming consumer acceptance these soups have gained. They cost no more than 4.6¢ per 6-ounce serving!

NEW! Display Material!

Designed to get your new soup sales off to a lightning start! Full-color back-bar banners – menu clip-ons and tent cards. See your Campbell representative or write directly to the Campbell Soup Company.

Turkey Noodle Soup

A wonderful full-flavored soup, with slow-simmered turkey broth, choice pieces of plump white and dark turkey meat and enriched egg noodles. Truly a soup with family appeal and proven sales potential!

Minestrone Soup

(Italian-Style Vegetable Soup)

Here's the soup you've been asking for – a *true* Italian-style Minestrone! Brimming with 12 garden vegetables, enriched spaghettini, cheese and spices – in rich beef stock. Your customers will want this Minestrone Soup often.

Chicken Vegetable Soup

A delicious new soup with great menu appeal. Combines chunks of chicken in golden chicken broth and country-style peas, carrots, potatoes and ribbon noodles all perfectly blended by Campbell's famous cooks.

Campbell Soup Company CAMDEN 1, N. J.

FINANCIAL

Total assets	$390,000
Total assets per bed	$ 3,900
Plant assets	$280,000
Plant assets per bed	$ 2,800
Per cent plant assets of total assets	71.8%
Total annual income	$595,000
Total income per patient day	$ 23.33
Annual patient income	$560,000
Patient income per patient day	$ 21.95
Per cent patient income of total income	94%
Total annual expenses	$555,000
Total expenses per patient day	$ 21.75
Annual payroll expenses	$295,000
Payroll expense per patient day	$ 11.55
Per cent payroll of total expenses	53%

DIETARY

Frequency of Hospitals With:	*Per Cent of Hospitals*
Dietitians (full-time or part-time)	73
Central food service layout	91
Decentralized food service layout	9
Selective menus for all patients	38
Selective menus for private patients only	12
No selective menus	50
Manual and centralized dishwashing	10
Manual and decentralized dishwashing	10
Mechanical and centralized dishwashing	77
Mechanical and decentralized dishwashing	3

UTILIZATION

An analysis of the kind, type and number of patients admitted to and using the 100 bed proprietary general hospital annually shows 4000 admissions; 40 admissions per bed; 725 live births; 25,500 patient days of care, and 3300 newborn infant days of care.

The daily adult census in the 100 bed proprietary general hospital is 70; the daily newborn census is nine.

The percentage of adult occupancy, then, is 70, and the average length of patient stay, 6.3 days.

Public Mental Hospitals Lack Adequate Staffs

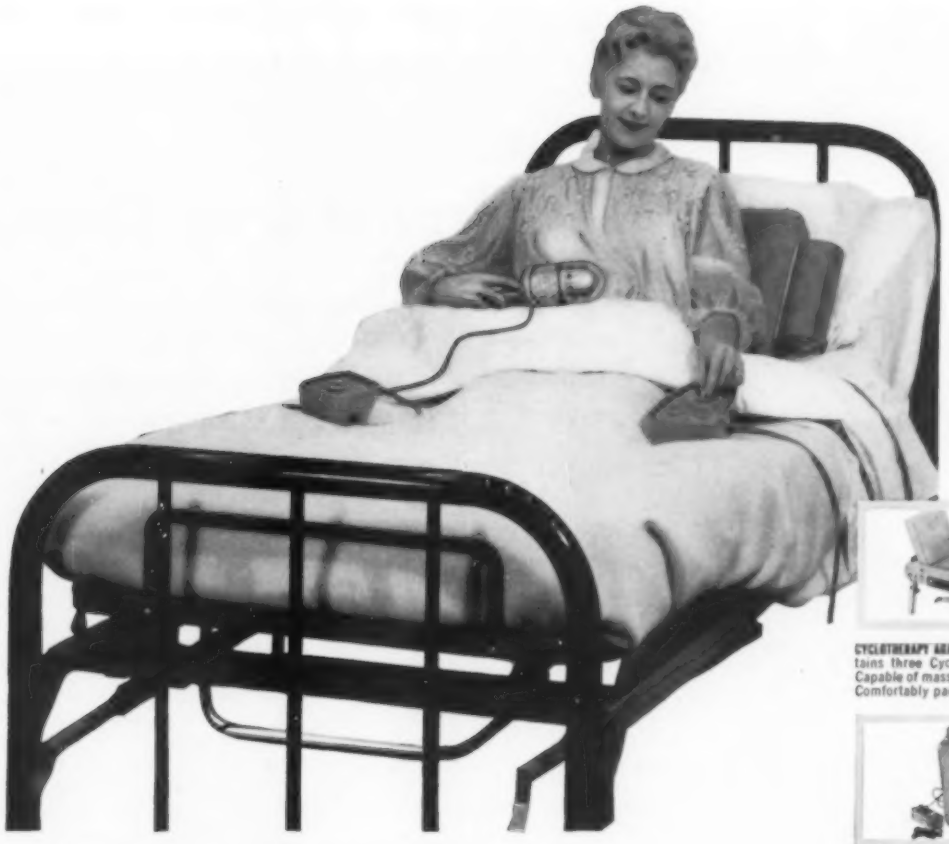
NEW YORK.—No state has an adequate number of personnel in its public mental hospitals, according to a report released recently by the American Psychiatric Association and the National Association for Mental Health.

The study of personnel in these hospitals during 1956 revealed a nationwide need for 63,344 employes, including physicians, psychologists, registered nurses, other nurses and attendants, and social workers.

According to the report, the greatest shortage is in registered nurse staffs. The national average is only 19.4 per cent of the number set as a minimum requirement by the psychiatric association. Total shortage was reported as 29,900 nurses.

In general, the report concluded, public mental hospitals have only one-fifth of the adequate number of nurses, slightly more than one-third of the needed social workers, less than half the physicians, two-thirds of the psychologists, and three-fourths of the attendant staff.

The National Association for Mental Health has announced plans for its 1958 mental health fund campaign, beginning with Mental Health Week, April 27-May 3, and continuing through the month of May.



CYCLOTHERAPY ADJUSTABLE TABLE. Contains three Cyclo-Massage units. Capable of massaging entire body. Comfortably padded.

PORTABLE HEAT AND MASSAGE PAD UNIT. Contains one Cyclotherapy unit for localized application. Patients can operate unit while in bed.

PORTABLE HAND UNIT. For direct massage application to any part of the body. (Automatic timers on all units.)

Cyclotherapy®

AIDS PATIENTS, HELPS REDUCE NURSING LOAD

The basic Cyclotherapy units shown on this page are multi-purpose appliances that have been medically evaluated and proved in leading hospitals and clinics throughout the country.

The Cyclotherapy action is a three-way, small amplitude, multi-directional action—horizontal, vertical, and cyclical—and penetrates deeply, yet gently, through the soft tissues as well as the bony structure of the body.

Numerous clinical studies indicate that Cyclotherapy is effective as an aid in the relief of many kinds of pain—particularly the pain associated with muscle spasm, arthritis, bursitis, fibrositis and rheumatism. These same studies reveal that this deeply penetrating physical action helps relieve nervous tension, and encourages deep, natural sleep. It is classified as a non-specific muscle relaxant, having analgesic properties in respect to pain associated with muscle spasm as well as non-specific sedative properties. Additional studies indicate that Cyclotherapy helps increase blood circulation in the areas of application.

CYCLOTHERAPY, INCORPORATED

New York, New York

EASES NURSING LOAD

Because Cyclotherapy portable units are easy to use, and are effective for self administration in convalescent post-operative cases as well as for use in many other types of cases, they frequently take the place of much time-consuming personal nursing care.

CLINICAL DATA AND OTHER DETAILED INFORMATION AVAILABLE ON REQUEST. Either write, outlining any specific problem you may have in mind, or simply fill in and mail coupon below.

Medical Research data available on request.

Guaranteed by Good Housekeeping

CYCLOTHERAPY, INC., Dept. MH – 258
11 East 68th Street, New York 21, N. Y.
Please send complete information on Cyclotherapy for use in hospitals and clinics. No obligation.
(please print)

Name..... Position.....

Institution.....

Address.....

.....

The Pharmacy Should Control Drug Samples

The method of issuance and control of drug samples described here protects patients, physicians and the hospital against abuses and, in many instances, has resulted in increased sales of ethical drug products

LOUIS P. JEFFREY

IN THE *Journal of the American Medical Association* some time ago, there appeared an article concerning the danger of discarded drug samples. It was reported that physicians' children have become ill from swallowing drug samples sent to their doctor-fathers. The busy physician too frequently does not realize the potential danger of leaving such samples on the desk, in a desk drawer, or throwing them into a wastebasket where they are easily accessible to children.

The Federal Drug Administration recently discovered another misuse of these sample drugs. A charwoman in a medical building was collecting samples from physicians' wastebaskets and selling them to an individual who was then reselling them without a prescription. This public health problem concerns the pharmacist. I believe that it is his professional obligation to discuss this tactfully with the physicians in his area, because they are probably completely unaware of the hazards they are creating.

One pharmacist visited several physicians, discussed the problem with them, and left a container in each physician's office into which the discarded samples could be placed. At given intervals, the containers were collected and the drugs were distributed to a local charity hospital to be dispensed in a proper manner. This system protects physicians and their families and disposes of the drugs by a method that will prevent any unethical sale or use of these drugs. Although this may not be an ideal solution, it is at least a step toward proper control of sample drugs.

Both of the problems mentioned deal with the physician either in his office or in a medical building. With many physicians' offices now being located in hospitals, could this not be a serious problem in a hospital as well as in a medical building? A method which was instituted at Albany Hospital, Albany, N. Y., and which has been effectively operated during the last two years is described here.

First, I should like to quote an administrative policy which exists at our hospital.

"It is contrary to hospital rules for drug company detail men to leave samples of new drugs anywhere except in the hospital pharmacy. No drugs may be given to the patients in the clinics unless they have been approved by the pharmacy committee for inclusion into the hospital formulary. This applies regardless of whether or not products may be obtained free.

"Samples of nonapproved drugs may not be accepted or used in the care of service patients or used in the hospital in care of service patients. The only exception to this is when a research project is being carried out with the approval of the research committee, and the drug is being supplied free by the manufacturer.

"Samples of nonapproved drugs or similar drugs may not be stored in any of the clinics or on any of the nursing floors in the hospital."

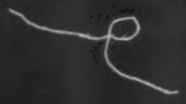
The initial step in solving the problem of drug samples was the establishment of a definite hospital policy with respect to such samples. With this policy as a guide, we proceeded to establish a system whereby drug samples would be stored, handled and dispensed through the pharmacy without inconveniencing the physician, the nurse, the patient, or the pharmacist.

The physician in the clinic sees the patient, decides whether he will require medication, and then proceeds to write a prescription. Sometimes a patient cannot pay for the medication for one reason or another. He may be a service or welfare patient who has not as yet received approval from proper authorities or a person who would not qualify as a welfare case owing to financial reasons but still could not afford to pay for medication, or a patient who is reluctant to be listed as a welfare case because of social standing. In such cases the clinic sample list is checked. If the physician prescribes a drug on this list, he stamps the prescription S.A. which indicates drug supplies will be drawn from sample stock. The pa-

Louis P. Jeffrey is chief pharmacist at Albany Hospital, Albany, N.Y., and he teaches pharmacology to students in Albany Medical Center's school of nursing and in Albany Hospital's practical nursing program. Currently serving as president of the Northeastern New York Society of Hospital Pharmacists, Mr. Jeffrey also is a member of several other pharmacists' organizations and works on a number of their committees. He received bachelor's and master's degrees from Massachusetts College of Pharmacy.

No Other Identification Band Attaches So Quickly... So Easily

INSERT A CARD... ADJUST THE STRAP... AND SNAP!



NEW!
Aren®
all-patient
identification
bands by

WILL ROSS, INC.

- Revolutionary *one-piece* design of white, non-toxic plastic
- No tools or small parts to handle
- Aren band is strong, supple and *simple* to apply
- Clear "picture-window" card holder
- Card holds all information recommended by American Hospital Assn.
- Adult cards in white; children's in pink, blue, and white
- Tamper-proof snap defies removal by patient

SEND FOR FREE SAMPLES NOW

WILL ROSS, INC., Milwaukee 12, Wisconsin, Dept. 85

Please send me free samples, descriptive literature and price lists on the new *Aren Identification Bands.*

Name _____

Hospital _____

Address _____

City _____ Zone _____ State _____

WILL ROSS, INC.

tient then brings the prescription to the pharmacy. A pharmacist dispenses the medication free of charge observing the usual outpatient dispensing precautions.

The clinic sample list which is available in each clinic is a compilation of drugs which have been supplied to the hospital "gratis." Only products in the formulary are included in this list. The list is revised by the pharmacy department regularly, with additions and deletions depending upon need, requests and manufacturer's compliance with supplying a particular product.

There are several advantages to the patient in having all his medication—including drug samples—dispensed from the pharmacy:

1. The pharmacy is the natural outlet for the dispensing of *all* drugs.
2. The medication is properly labeled, whereas if the drug is dispensed in the clinic usually no directions will be listed on the container.
3. It prevents the patient from knowing and inquiring about what medication he is taking.
4. The prescription serves as a safety measure for the physician with the pharmacist acting as a drug consultant.
5. This system does not encourage the dispensing of drugs by physicians, which is one of today's major intra-professional problems.

The availability of a single department that can be used as a center for the distribution of samples, literature and other material is an asset to the manufacturer. For instance, at the present time, we distribute through the hospital pharmacy several pharmaceutical house organ periodicals, various books, physicians' gift boxes, and many other items. Other advantages are:

1. The hospital maintains a systematic and orderly program for the distribution of sample drug items.
2. It offers the manufacturer a place to go with his questions, material and samples, so that they can be distributed properly.
3. The medical center can exercise proper control over the use of samples by seeing that they do not fall into the hands of unauthorized personnel.
4. The patient, hospital and physician are protected by the proper screening action of the pharmacy committee.
5. The pharmacy department is established as the proper information center concerning all new drugs, including samples.
6. The establishment of a definite drug exhibit arrangement is made possible through this program.

The adoption of a procedure for routine checking of nursing stations and clinics has enabled the pharmacy department to enforce the hospital's policies effectively with regard to samples. Primarily, an inspection of the nursing station is made to check routine drugs, floor stock, and narcotics. Since the establishment of definite policies with respect to drug samples, we now use this routine checkup method as a means of keeping a check on drug samples.

Once a month, a member of the pharmacy department makes rounds with a member of the nursing service to inspect the drug cabinets on the wards. If, in checking these cabinets, sample material is discovered which does not belong on the floor, the drug is removed from the unit. If this material has been left by a manufacturer's representative without proper hospital authorization, we proceed to discuss this situation with the salesman. He is cautioned against the violation of hospital policies and requested that, in the future, clearance be made through the pharmacy.

In most hospitals today, nursing station cabinets are stocked with a great number of medications and the addition of new or different drugs to this cabinet adds to the problem of storage and often results in confusion among the staff. We have found the nursing service is quite willing to cooperate in the control of drug samples on nursing stations and in the clinics. This has been beneficial to both departments.

The use of a formulary as a guide, reference book, or policy book with respect to drugs in hospitals is now familiar. At our hospital, this publication of the pharmacy committee is used to control the type and form of medication that is dispensed to service or welfare patient, and also serves as a screening program in the use of new drugs. First, it protects the service patient, who is a hospital responsibility, from relatively new and unproved drugs. Second, it prevents the issuance of more than one product with same generic title to this patient.

If the physician prescribes for a clinic, welfare or service patient a drug which is not approved by the pharmacy committee of the staff, that medication is not made available to the patient unless special temporary approval is obtained from the medical director or chairman of the pharmacy committee. As stated previously, this policy applies regardless of whether or not the product can be obtained free of charge. If the medication prescribed by the physician is in the formulary and sample material is available, then the prescription may

when rapid relief of allergic symptoms is needed

Benadryl®

(diphenhydramine hydrochloride, Parke-Davis)

AMPOULES

STERI-VIALS®

Parenteral BENADRYL in the new, higher strength ampoule is especially well suited for prompt control of acute allergic reactions occurring as results of blood transfusions or administration of serums or drugs. Added to infusion fluid or blood prior to administration, BENADRYL affords excellent protection against allergic reactions.

BENADRYL solution may be administered intravenously or intramuscularly, although the intravenous route is preferable.

NEW BENADRYL Hydrochloride Ampoules, now available in a 1-cc. ampoule, 50 mg. per cc., in boxes of 10.

BENADRYL Hydrochloride Steri-Vials available in 10 and 30 cc. vials, 10 mg. per cc.

PARKE, DAVIS & COMPANY

DETROIT 32, MICHIGAN

24358

be filled by the pharmacy department from this sample supply.

Drug exhibits are considered an asset by the hospital and the manufacturer, but to offer the most to each of the participating members these exhibits must be conducted under definite policies with respect to location, products, hours, day of the week, and representatives present.

In our particular geographic area, we have an organization composed of medical service representatives. The group, the Medical Service Representative Society of the Capital District, cooperates with the hospital in arranging, conducting and supervising hospital displays. This cooperation between the organization and the hospital has formed the basis upon which a definite schedule was established for routine drug exhibits.

Drug exhibits are conducted once a month on a definite day of the week at the same time each month. On this particular day, four pharmaceutical companies simultaneously display drug products all day long. Each representative is given a large and relatively private area where he may detail or discuss his products with the physician. At these exhibits representatives may display trade or sample packages, but they may not distribute any samples to those attending the exhibit. This is a literature display only, since this is all that the representative is allowed to pass out.

If the medical service representative wishes to give a physician a sample of the products exhibited or any other product, he must abide by the following established policies:

1. If the sample to be dispensed is for personal use only, as much as is actually needed may be given to the physician but it is recommended that this be cleared through the pharmacy department.

2. If the drug is to be used in the hospital, it must be cleared by the pharmacy and therapeutics committee.

3. If the material is mailed to the physician, it is requested that this be mailed to his home address since it is usually for his personal use.

4. At the end of a display day, each representative makes a report of the samples requested. At a later time, with proper permission, the samples are distributed.

5. Under no circumstances are the samples to be left any place in the hospital other than at the pharmacy.

The successful functioning of most systems depends upon the proper, honest and intelligent supervision of the system. This is also true with respect to a drug samples control program. At the present time, we average two to three "S.A. Prescriptions" a day. We have found that the privilege of controlling samples is not abused by anyone—the medical staff, the nursing department or the pharmacy department—at our hospital.

The distribution of samples to be dispensed on the prescription of a clinic patient has in no way decreased the routine prescription business of the outpatient department. On the contrary, since the rigid control on sample drugs has been enforced, the number of prescriptions filled on an outpatient basis has tripled. The reason for this is because samples that were once stored in the clinics were distributed to all patients as medication free of charge. No prescription was ever written, specific directions in writing were seldom given to the patient, and no permanent file was kept on the medication dispensed. Also, this method developed early in the physician's experience as a resident or intern the practice of dispensing medication at the time of the patient's visit. All of these disadvantages of drug dispensing have been corrected. Therefore, instead of dispensing samples, the physician writes out a prescription and the patient, having it filled at the pharmacy, pays for the medication; hence, the ultimate increase in outpatient prescription filling.

What does the physician think of this program? Generally speaking, he endorses it and gives his full cooperation to the pharmacy department since it is designed to benefit the patient—the prime objective of any health team. Even attending physicians bring drug samples to the pharmacy to be stocked under this sample control program. This enables them to clean their offices and yet not have to destroy the material or have drug samples handled improperly.

The institution of this sample distribution program is not meant to put a check on the manufacturer, the representative, or any hospital staff member. It is developed to establish a definite system which is necessary in a medical center where many students are involved in its over-all function and where many new drugs are continuously being introduced, experimentally and otherwise. We have received excellent cooperation from the manufacturers and their representatives. They have discovered that in many instances this has been beneficial to the increased sale of their products. The ethical pharmaceutical manufacturer intends that the distribution of his samples be done in such a manner as to be beneficial to the patient, the physician, the hospital, and to the manufacturer himself.

hepatitis-free blood plasma substitute:

PLAZMOID®

brand of gelatin solution

Upjohn

THE UPJOHN COMPANY
KALAMAZOO, MICHIGAN

Plazmoid is purified gelatin in isotonic solution of sodium chloride. It parallels plasma in colloidal osmotic effects, yet is much less expensive, and free of the possibility of transmitting serum jaundice.

Available in bottles of 500 cc.

®TRADEMARK REG. U. S. PAT. OFF.

Recent Developments in Antibiotics

A review of papers and panel discussions presented at the Antibiotic Symposium, with a summary of some of the important recent developments in the field

WHAT is happening in the field of antibiotics and chemotherapy came under intensive study at the fifth annual Antibiotic Symposium held in Washington, D.C., last October. Some of the highlights of recent developments in the field, as reported in the panel discussions and individual presentations, are summarized here:

Amphotericin. Amphotericin is a relatively new antifungal antibiotic derived from a species of Streptomyces. Like nystatin, a similar antifungal antibiotic, amphotericin is insoluble in water, a physical property which precludes its use for treating systemic fungus infections.

Amphotericin has been solubilized by being combined with sodium desoxycholate. The combination does not form a true solution but a fine colloidal suspension which is stable at room temperature for several months if protected from light. It is considerably more toxic than the insoluble form, but this varies greatly depending upon the animal species. An intravenous dose of 5 mg. per kg. of body weight in rabbits resulted in death of 62 per cent of animals within 30 minutes. One mg. per kg. intravenously in dogs caused emesis and hematemesis. Some of these dogs died after two weeks following the drug. Monkeys were able to tolerate a dose of 2 mg. per kg. without manifesting serious side effects. Some of these exhibited an elevation of the blood urea nitrogen, possibly owing to a renotoxic effect. In general there were no delayed toxic effects with the exception of one monkey in which the blood urea nitrogen was unusually high. This animal also developed liver damage. Doses of 1 mg. per kg. of body weight may be administered to man by intravenous drip without serious side effects.

Amphotericin B in the treatment of systemic fungal diseases. This was a report of 15 cases of systemic fungus infections treated intravenously with amphotericin. These included cryptococcic meningitis, blastomycosis, histoplasmosis and coccidioidomycosis. The drug was given both orally (5 mg. per kg. per day) and intravenously (1.3 mg. per kg. per day) simultaneously. The most consistent side effects noted were nausea, anorexia and diarrhea following oral medication, and chills and fever, azotemia and paresthesia following intravenous administration. The blood urea nitrogen was elevated to a range of 28 to 34 mg. per cent. Some of these patients are completely well after one year and the cultures are negative. In general histoplasmosis and blastomycosis responded better than cryptococcosis and coccidioidomycosis.

Another report gave the results of amphotericin B in the treatment of 6 cases of cryptococcic meningitis. These patients received 1 mg. per kg. of body weight. The drug dissolved in one liter of isotonic saline and was administered slowly intravenously over a six-hour period. Five of the patients responded quite well and are symptom free after intervals of three to nine months since therapy. The sixth patient was moribund at the outset and died one month after therapy was initiated. The side reactions in this series consisted of nausea and vomiting, chills and fever, phlebitis at the site of injection and a transient elevation of the blood urea nitrogen. Chills, fever, nausea and vomiting are minimized by the concurrent administration of antihistaminic agents.

Methionine as a urinary tract antiseptic. The author stated that urine normally contains an antibacterial substance which is more effective at a low pH. He pointed out that carnivores tended to have an acid urine while herbivores tended to have an alkaline urine. The acidity of the urine in the former was attributed largely to the presence of methionine in the diet. Like ammonium chloride, methionine, when given by mouth, has an acidifying effect on the urine. In contrast to the action of ammonium chloride, however, this effect persists for several days following the last dose. Methionine is metabolized in the body to form sulfate which is excreted in the urine. The pH of the urine in man was decreased from an average of 6.0 to 4.5 in a large series of subjects which received 18 grams of methionine orally each day for several days. Their urine had a marked antibacterial effect on most urinary tract pathogens, including pseudamonas and proteus. The bacterial count of the urine was decreased in some cases from 10 million to a range of 1000 to 10,000 per ml. Those cases of urinary tract infection which did not respond well to methionine alone exhibited a rapid response when mandelamine (mandelic acid and methenamine) was added in a dose of 3 to 6 grams daily. The nature of the antibacterial substance in urine is not yet clear.

Clinical evaluation of sulfamethoxypyridazine (kinex) in children. Sulfamethoxypyridazine is a relatively new sulfa drug which is characterized by an extremely slow rate of excretion. Following oral administration of therapeutic doses, peak blood levels (18 mg. per cent) occur within four hours. This gradually decreases so that 24 hours later the concentration is 7 mg. per cent and 2 to 3 mg. per cent after 48 hours. These blood levels resulted from a single oral dose of 500 mg. The drug was found to be rapidly effective in children with cellulitis, septicemia,

DAVOL *puts color into catheters*

NEW COLOR CODED CATHETERS

easy to sort...
select...
recognize at a glance...

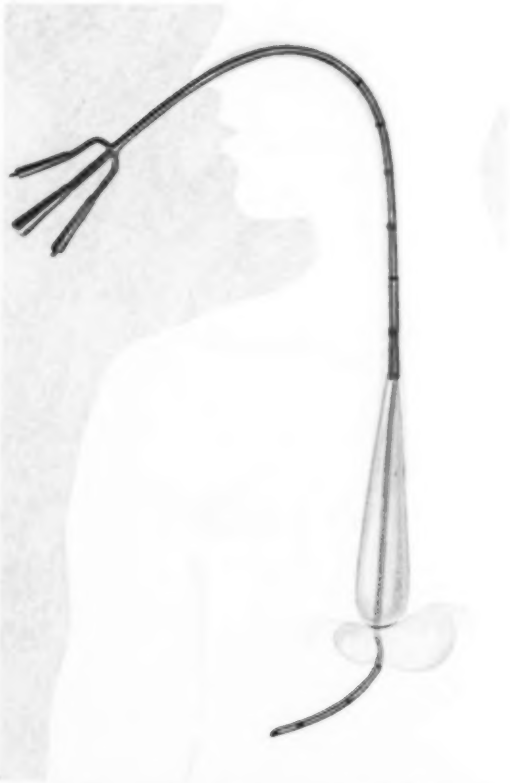
- NELATON (solid tip)
- ROBINSON
- WHISTLE TIP
- OXYGEN

Save time, money. Increase safety and efficiency in operating room, ward and central supply

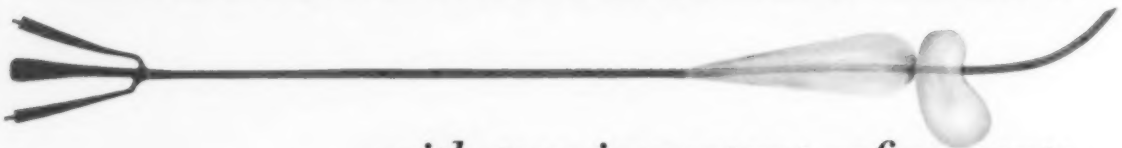
The four most widely used rubber catheter styles are now available in distinctive colors that guarantee immediate recognition.
O. R., Ward and Central Supply personnel can pick the right color coded catheter at a glance, thus assuring operating room safety.
Davol Color Coded Catheters are of the same high standard of quality that distinguishes all Davol Surgical and Hospital Products...and are available at no increase in cost.

Order From Your Davol Hospital Supply Wholesaler DAVOL RUBBER COMPANY PROVIDENCE 2, R. I.

for emergency control of hemorrhage from esophageal varices



NEW IMPROVED BLAKEMORE NASOGASTRIC TUBES



with two important refinements

- Asymmetrical gastric balloon conforms to stomach contour.
- Redesigned esophageal balloon provides adequate hemostasis at bleeding sites.

Refinements afford more effective control over hemorrhage from the Esophageal Varices. Continuous pressure over a greater area is possible with the change from a spherical gastric balloon to one that conforms to the stomach contour when inflated.

Position maintenance is improved because the esophageal balloon is constructed to prevent its upward expansion and provide adequate hemostasis at the bleeding site. At the same time a relatively low intra balloon pressure is maintained.

The Blakemore Tube has a main 38" tube, with whistle tip, multiple eyes and funnel end for aspiration and feeding. Supplied with nasal cuff to aid in position maintenance, absorb excess nasal secretions, and reduce local trauma to the nostril. Separate airways for inflating both balloons are incorporated in the catheter. Child size Blakemore Tube also available from your Surgical Supply Dealer.

DAVOL RUBBER COMPANY
PROVIDENCE 2, RHODE ISLAND

bronchitis and pyelonephritis. The recommended daily dose is 500 mg. as a single dose. No side reactions have been noted.

The drug is eliminated from the body by renal excretion but the exact mechanism of detoxication is not well understood.

Correction of simple growth failure in the tropics with low levels of oxytetracycline. Fifty-four understatured children were given oxytetracycline in a daily dose of 50 mg. Another group received 10 mg. by mouth daily. The third group of 243 understatured children served as controls and were given lysine as a placebo. The group which received oxytetracycline at the 50 mg. dose level showed a statistically significant increase in the rate of growth as compared with those on the 10 mg. dose or those on lysine. Units of growth measurement were determined by Dr. Wetzel of Cleveland. There was no evidence of increased sensitivity, as determined by a dermal test, in those on long-term oxytetracycline. Also, there was no evidence of the development of resistant strains of bacteria. No allergic reactions were noted in any case.

Ristocetin. Ristocetin is a new antibiotic which is chiefly effective against Gram-positive organisms. It exists as two fractions, A and B, both having a similar antibiotic spectrum. The minimal inhibitory concentrations for ristocetin A and B vary between 2 and 5 micrograms per ml. for susceptible organisms. Ristocetin B is about three times as active as A. The fraction B is also more toxic than A. The intravenous LD-50 for A in mice is 1350 mg. per kg., but 645 for Ristocetin B. Chronic toxicity studies in experimental animals revealed no effects at a dose level of 100 mg. per kg. per day for a period of nine weeks.

The drug is not absorbed orally and must be administered intramuscularly or intravenously. Both fractions are inert pharmacologically as shown in the anesthetized dog. Bradycardia and hypotension observed with the earlier lots were found to be caused by impurities. A single intravenous dose produced a blood level of 600 micrograms per ml. for about one-half hour, but this rapidly declined to 4 micrograms per ml. after about eight hours. The rapid fall in blood levels was attributed to a fast rate of diffusion of the drug into body fluids and tissues. No appreciable amounts could be detected in bile or cerebrospinal fluid.

The Ristocetins are eliminated from the body chiefly by renal excretion. About 80 per cent could be accounted for in the urine within 24 hours following a single I.V. dose. They are excreted by glomerular filtration but are reabsorbed to some extent by the renal tubules. High concentrations occur in the urine. There is no evidence that Ristocetin is bound to plasma proteins.

After repeated transfers Staphylococcus albus developed a 64-fold increase in resistance to Ristocetin A but only an 8-fold increase to B. Staph. aureus showed only a 2- to 4-fold increase in resistance. With a mixture of 80 per cent A and 20 per cent B, a dose of 1.6 mg. per kg. protected mice against a lethal dose of D. pneumoniae.

Clinical uses of Ristocetin. Romansky reported on the successful short-term treatment of seven cases of enterococcal and staphylococcal endocarditis. One of these patients had received 5 billion units of penicillin without apparent results but all of them promptly responded to Ristocetin. The usual dose was 1.25 grams intravenously twice daily. The total dose ranged between 24 and 70 grams and the longest duration of therapy was four weeks. It was felt that two weeks of therapy probably would have been sufficient. The rapid response was ascribed to the marked penetrating power of Ristocetin. A transient leukopenia was noted in one patient who received a dose of 9 grams intravenously. A dose of 25 mg. per kg. per day intravenously seemed to have destroyed all susceptible bacteria. The bactericidal concentration was found to be quite close to the bacteriostatic concentration.

Ristocetin exhibits no effect on Gram-negative organisms. An oral dose of 0.5 gram will eliminate all of the Gram-positive organisms in the GI tract but the total bacterial count remains more or less constant. The Gram-negative organisms increased in proportion to the decrease in Gram-positive bacteria. There was a tendency of yeast-like organisms to increase also.

Randall Lecture: "Patient, Doctor, Bug and Drug." It was pointed out by Dr. Jawetz of the University of California that the position of antibiotics in medicine is quite secure, but that they should be used "with reason and knowledge." The lecturer pointed out the need for more objective measurements of the efficacy of antibiotics. As regards the interaction between "bug and drug" Jawetz maintained that synergism between antibiotics may have a pleasant emotional appeal but generally may have more disadvantages than merits.

The problem of resistant strains of staphylococcic organisms in hospitals was discussed, with suggestions as to how to cope with this situation: Adhere to rigid asepsis; limit the use of catheters, a great source of spread; avoid the needless prophylactic use of antibiotics; evaluate the need for antibiotics in each case; use antibiotics to fit the patient, not to soothe the psyche; restrict or limit the use of one antibiotic so as to minimize the development of resistant strains of staphylococci. Serious infections should be treated as early and as vigorously as possible with antibiotics or combinations which exert a bactericidal action.

Panel discussion on rheumatic fever prophylaxis, by Drs. Breese, Stollerman, Markowitz, Curry and Massell. Oral penicillin was felt to be as effective as parenteral penicillin in rheumatic fever prophylaxis. The recurrence rate in patients so treated was 5.5 per cent, chiefly owing to interruption of therapy. The recurrence rate was found to be 1 to 2 per cent for all forms of penicillin under ideal conditions. The rate in untreated patients was stated as being 5 to 18 per cent, varying with age and time of initial rheumatic attack. The usual prophylactic dose was recommended as being 200,000 units daily but should be doubled in the face of heavy exposure. Epidemic strains of streptococci (group A) seemed to be more likely to cause rheumatic fever, but varied in their rheumatogenicity. The rate of infection of siblings of patients with rheumatic fever averaged about 25 per cent, but this too varied with age. The opinion differed as to whether all sibling contacts should be treated prophylactically.

Nationwide survey of severe reactions to antibiotics. This survey by Dr. Welch covered all cities with a population of 100,000 or more, representing 198,000 hospital beds, or a third of all hospital beds in the United States. Most of the severe life-threatening reactions occurred from the parenteral use of penicillin. There were nearly 3000 such reactions, including 809 anaphylactoid reactions. The death rate from the latter was approximately 10 per cent. Relatively few reactions were seen from the oral administration of penicillin. There were 46 blood dyscrasias and 27 deaths, 11 deaths resulting from chloramphenicol, and five from penicillin, streptomycin, a combination of streptomycin and penicillin, and the tetracyclines. There were 74 superinfections caused by staphylococcic enterocolitis and 26 deaths. The reactions to penicillin occurred from the administration of 900 tons of the antibiotic, or an equivalent of 3 billion doses of 300,000 units each. The survey was conducted over a three-year period, 1954, 1955 and 1956.

Penicillinase in the treatment of allergic reactions to penicillin. According to Becker of Madison, Wis., peni-

YOU ASKED FOR IT...

CONVENIENT DISPENSING!

FLEX-STRAWS NOW PACKED
in a convenient DISPENSER BOX
MINIMUM HANDLING...MAXIMUM PROTECTION

FLEX-STRAWS are distributed quickly and efficiently from the new dispenser box. Straws are removed at corrugated section so that it is never necessary to touch either the end which is immersed or the end which touches the mouth; assuring maximum protection and sanitation. One or several FLEX-STRAWS can be dispensed with minimum time and effort. The dispenser tab may be closed between uses. ORDER FROM YOUR DISTRIBUTOR NOW.

FLEX-STRAW COMPANY 2040 BROADWAY • SANTA MONICA, CALIF.

Canadian Distributors: Ingram & Bell, Ltd.
Toronto • Montreal • Winnipeg • Calgary • Vancouver

cillinase rapidly hydrolyzes circulating penicillin to form penicilloic acid which is nonallergenic and nontoxic. Forty-six patients who developed reactions to penicillin were treated with penicillinase. The symptoms included urticaria, joint swelling, and angioneurotic edema. Excellent results were obtained in 24 patients. The other 22 were treated with other agents prior to penicillinase without apparent effect. When penicillinase was given, the allergic responses were brought under control. The three patients who failed to respond to penicillinase were not treated until weeks or months after the reaction had occurred.

Penicillinase quickly destroys the antigen, but the vascular repair of damage caused by allergy may take several days. Allergic reactions not due to penicillin will not respond to the enzyme. Penicillinase is administered intramuscularly at two to three-day intervals. It may be necessary to give three or four doses, but allergic symptoms can be suppressed with steroids in the meantime.

Hydrocortisone as supplemental therapy in acute bacterial meningitis. Dr. Lepper reported the results obtained when hydrocortisone was employed as supplemental therapy with chemotherapeutic agents in the treatment of a variety of bacterial meningitides. This was an alternate case study in which the steroid was given intravenously in doses up to 300 mg. per day. While the cortisone did not alter the death rate, it shortened the duration of fever. The spinal fluid glucose returned to normal more rapidly as did the spinal fluid protein. The leukocyte count showed the same trend.

Host reactions as a part of the clinical picture of infectious diseases. The author, Dr. Kremer, pointed out that infections generally result in inflammation and its sequelae: pain, discomfort, dysfunction, fever, allergy and immunity. All of these summate to produce a reactive panic. This can be greatly altered by agents which modify host reaction, or "host-reaction-modifiers." The steroids are broad spectrum host-reaction-modifiers. They do not alter serum globulin nor the pituitary-adrenal mechanism. Phenylbutazone, like some of the steroids, exerts a specific antiflammatory effect.

The rôle of gamma globulin in infectious diseases and its relationship to the action of antibiotics. A number of papers were presented emphasizing the relationship of gamma globulin either alone or in combination with antibiotics in the control of infectious diseases. Mice infected with lethal doses of SR-11 strain of Typhi murium were protected to the extent of 5 per cent with GG and 40 per cent with chloramphenicol. A combination of chloramphenicol and GG offered 90 per cent protection. This was labeled "synergistic action." GG is thought to exert an opsonizing effect on bacteria.

GG was demonstrated to contain specific antibodies. When certain pathogens were kept in contact with GG at 37° C. for 30 minutes and then centrifuged, the supernatant fluid lost all of its protective action against those bacteria, but retained activity against other organisms.

A determination of GG levels offers no index of protective action, however, except when it is extremely low. The level of this protein may be normal and still it may be incapable of forming antibodies. In one series it was found that children who were extremely susceptible to infections also had a very low level of GG.

Host resistance and chemotherapy. In a panel discussion in which Drs. Benson, Braun, Fisher, Lepow, Suter and Waisbren participated, Dr. Suter emphasized the rôle of polymorphonuclear leukocytes, monocytes, and reticuloendothelial cells in infections. Monocytes are the most active as indicated by rates of oxygen uptake. Phagocytic ability is maximal at a pH of 7.5.

Dr. Lepow discussed the rôle of properdin in host resistance to infections. Properdin is beta-euglobulin with a molecular weight of about 1 million, having an isoelectric point at pH 5.6. Properdin + complement in the presence of magnesium ions results in a bactericidal, viricidal and a hemolytic action. It has little or no serological specificity and hence is not just another antibody. It is present in normal serum and requires a co-factor for action. Many substances interact with properdin, including zymosans (walls of yeast cells) and bacterial cells. It seems to facilitate lysis of bacteria. Small amounts of bacterial endotoxins stimulate the production of properdin while large amounts of endotoxin will suppress it. The properdin titer in serum at a given time is determined by a balance between invading organisms and other host factors.

Dr. Benson discussed other factors which control properdin levels in serum. The levels are decreased in pulmonary complications, hemorrhage, and peritonitis. Surgery in the presence of acute infections will greatly reduce the properdin levels (below 2 units per ml. or less). Bullet wounds cause a similar effect. An elevated body temperature will decrease properdin levels. Abscesses contain a substance which seems to inactivate properdin; consequently when they are drained, the properdin levels fall markedly. Blood transfusions with large quantities of blood (5 pints or more) will decrease properdin titers.

Dr. Braun discussed cellular products of bacteria or the host which may decrease or increase resistance in bacteria. Serum from infected animals favors the development of avirulent strains. When avirulent types are treated in the test tube with DNA and DNA-ase they rapidly become virulent. This change results from the presence of DNA breakdown products. These products are converted by bacteria into a substance or substances which are toxic to the avirulents, allowing the virulents to predominate. This action of DNA breakdown products is antagonized by high concentrations of calcium ions. Kinetin riboside (6-furfuryl-amino-9-beta-d-ribofuranosyl purine) is also a highly effective antagonist and may exert a therapeutic effect because of this action.

Dr. Fisher discussed the rôle of antibodies and gamma globulin in the control of infections. GG plus chloramphenicol produce an acceleration of phagocytic destruction of the staphylococci.

Antibiotic combinations. There was a great deal of controversy as to whether or not oleandomycin in combination with tetracycline exerted a synergistic effect. One worker reported what appeared to be a synergistic effect of this combination in treating brucellosis in Argentina. The average dose was 3 grams daily for 10 days. Another study showed that oleandomycin was synergistic *in vitro* when combined with chloramphenicol and erythromycin.

Sidney Ross presented a paper showing that oleandomycin in combination with tetracycline had no synergistic effect. Fifteen healthy adults were given each drug separately and in combination and the minimal inhibitory concentration of the drug(s) in the serum was determined against certain susceptible bacterial pathogens. The combination did not exhibit a greater killing effect than the separate constituents. Similar *in vitro* studies supported the findings of Ross.

Dr. Dowling pointed out the fallacy of the tube method as a means of indicating synergism of antibiotic combinations, since the method is based upon minimal inhibitory concentrations and does not indicate the rate of killing. He suggested that more effort should be devoted to developing an *in vivo* experimental method for measuring synergistic action, addition or antagonism of antibiotic combinations. He pointed out

that there is no parallelism between the clinical response and the test tube findings, and that what appeared to be slight differences in clinical responses to the antibiotic combinations may be caused by a variety of factors.

Succinic acid esters of chloramphenicol. The mono-succinic and di-succinic acid esters of chloramphenicol are highly water-soluble and can be administered intramuscularly without irritation but are not appreciably absorbed orally. The antibacterial activity is based upon the release of chloramphenicol. Some of the di-succinate is excreted in the urine unchanged. The chloramphenicol succinates are distributed to all body fluids and tissues, including the brain. Highest levels are seen in the liver and kidney. High levels persist up to eight hours following intravenous administration but are even more prolonged following intramuscular administration.

Oxytetracycline and tetracycline in Asian influenza in the Philippines. During May and June 1957, the attack rate of Asian influenza in the Philippines was 70 per cent and the death rate was 16.35 per 100,000, chiefly due to secondary complications. The average duration of fever was reduced from 6.68 days to 3.86 days when oxytetracycline and tetracycline were administered. The death rate was highest among those suffering malnutrition and chronic diseases such as congestive heart failure. The most serious complications of the epidemic were hemorrhagic pneumonitis and laryngotracheal bronchitis.

Antibiotics as anti-tumor and anti-viral substances: A panel discussion consisting of Drs. Stock, Burchenal, Eaton, Ehrlich, Haas and Schabel.

Several antibiotics were listed as having anti-tumor effects on transplantable tumors in rodents. Of the anti-tumor agents Azoserine had been studied most extensively. Burchenal reported on the response of humans to Azoserine (O-diazoacetyl-L-serine) in daily doses of 5 to 10 mg. per kg. intravenously. Five of six patients with Hodgkin's disease showed a marked reduction in body temperature for about two weeks only. There were prolonged remissions in children with leukemia when Azoserine, 2.5 mg. per kg., was given along with 6-mercaptopurines. To date remissions have lasted up to 20 months. No active regression of solid tumors has been noted. The chief side effects of Azoserine include marked redness and soreness of the tongue and dermal ulcerations.

Actinomycins caused complete disappearance of metastatic embryonal tumors in children as indicated by x-ray. One child with a Wilm's tumor that was not altered by x-ray showed complete disappearance of the tumor when actinomycins were given. These agents, too, produced ulcerations of the tongue and skin. The dermal effects were additive to x-ray effects.

It was generally agreed that antibiotics are ineffective against human virus infections. Some antibiotics have been shown to have an antiviral action in tissue cultures and in egg cultures. Erhlichin, Netropsin, and Viscosin may exert an antiviral effect on the polio virus and the influenza virus in the mouse but not in man. Many of the penicillium filtrates exhibit a broad antiviral spectrum against neurotropic viruses but are too toxic for human use, having a therapeutic index of only about 2. Noformicin or Mk-61 (Merck) selectively inhibits nucleoprotein synthesis and nucleic acid metabolism by viruses.

Several antibiotics appear to have a sparing effect. The animals survive longer with them but the antibiotics are incapable of eliminating the virus. Results to date suggest that antibiotics are more likely to exert a chemoprophylactic action than a chemotherapeutic effect against viruses.—THEODORE R. SHERROD, PH.D., M.D.

"Going-out" patients...sooner

with GANTRISIN Roche

The treatment period is shortened and patients get back in stride sooner with Gantrisin, the dependable wide-spectrum sulfonamide. Beds become vacant faster in urological, medical and surgical wards.

Gantrisin is highly soluble and well tolerated without forced fluids or alkalis.

For any of the oral, parenteral and topical forms of Gantrisin, order direct from Roche through our special hospital price program.

Gantrisin®—brand of sulfisoxazole

ROCHE

Roche Laboratories • Division of Hoffmann-La Roche Inc • Nutley 10 • N. J.

Aged Patients Need Lessons in Nutrition

Although the nutritional needs of the aged patient will be met while he is in the hospital, he also should be taught what he should eat, and why, when he gets home. The author explains how doctor and nurse can educate the aged to good eating habits in terms the layman can understand

MARGARET C. MOORE

CHANGE in and around the cells of the human body is perpetual. Once certain structures, like enamel of the teeth, were thought to be static after the period of formation; now it can be demonstrated that radioactive phosphorus appears in the enamel a few hours after its ingestion. Throughout life, the efficiency or inefficiency of the body depends on its nutrition and its supply of oxygen as modified by stresses and environment.

In an older person, the inadequate, adequate or optimum degree in which these factors have operated may well have determined whether the person is old at 50 years or young at 80. Outside environmental factors, such as climate, geography, community health standards and sanitation, certainly contain predisposing conditions which influence health and well-being. When a person grows older, most of the provoking factors that influence his health are found within him. They are his own habits and his mode of life. If his habits have brought on a disease condition, such as a nutritional deficiency or a disease induced by such a deficiency, then his habits are likely to perpetuate the condition.

At the outset, it would be well to caution that nutrition should not be thought of as being synonymous with dietary habits. Dietary intake, however, does play a tremendously important part in good nutrition; if the nutrient supply is poor, unbalanced or imbalanced, it is surely a limiting factor. In its true sense, nutrition is concerned with what and how much food is eaten, with the digestion of that food, with the transportation of digested nutrients to all parts of the body, with the use of these nutrients, and finally with the elimination of waste products. Against this definition, what then can be said of the nutritional problems of the older person, for there is wear and tear that seems to come with age. To most people there comes a time when the arm seems too short and bifocals must be worn, but few recognize the more subtle changes that are probably much more important. Bad teeth, changed living conditions, or food fads may have altered an otherwise good dietary intake. So simple a thing as becoming a television addict may have modified food intake.

Basal metabolic rate may have slowed, making increased weight more likely; less exercise may have changed the ratio of body fat to muscle tissue; there tends to be less hydrochloric acid in the stomach; digestive enzymes may be fewer; glucose tolerance curves tend to be abnormal; the body is less likely to be in nitrogen and calcium balance; low plasma ascorbic acid as well as less than normal content of other vitamins is a statistical possibility; hemoglobin is likely to be low and blood cholesterol high; circulatory impairment of some degree is almost the rule; waste elimination is likely to be a problem; the body adjusts to change and stress less quickly and less well. Temperature changes hurt; gross depletion of the chloride ion, as through excessive sweating in the summer, is more likely when one is old. Apparently, in old age, cells become more vulnerable to lowered oxygen tension. The parenchyma cells of glands, heart muscle, brain and kidney are extremely dependent upon oxygen supply.

Statistically, these changes characterize the aging population; all of these changes may not occur in any one person, and all may not be necessary adjuncts of old age. In fact, rats

Presented at the sectional meeting of the American College of Surgeons, New Orleans, 1957.

Margaret C. Moore is consultant on nutrition for the Louisiana State Department of Health, and in that capacity has developed the state's public health nutrition program. Scientific studies are translated by the department into terms of everyday foods, with regard for local habits and conditions. This article is part of the planning that went into the program for supervising nursing home food services, when licensing of these homes was begun by the department. Louisiana is one of the seven states to have had continuous direction of its nutrition services.

ACTUAL SIZE

NEW! *Personalized* FOIL TEA TAGS

Match book size

An unusual and effective new form of advertising for your establishment . . . Sexton Personalized Foil Tea Tags!

These new foil tea tags are now available in small enough quantities for use in individual hotels, restaurants and clubs as well as chain organizations.

Our new match book size foil tea tags provide as much advertising space as match book covers. This gives you twice as much space for your message as an ordinary tea tag.

The services of our Art Department are available to you to provide your message and design in the colors of your choice. The distinctive colored foil backgrounds make your personalized tag more effective than ever before.

Our superb flowery Darjeeling blend tea surpasses ordinary commercial teas in flavor and will bring you repeat business and compliments. It is a tea with which you can be proud to associate your name.

See your Sexton representative for complete information or write:

John Sexton & Co., P.O. Box JS, Chicago 90, Ill.

Sexton *Quality Foods*

DIAMOND ANNIVERSARY
1883 • 1958

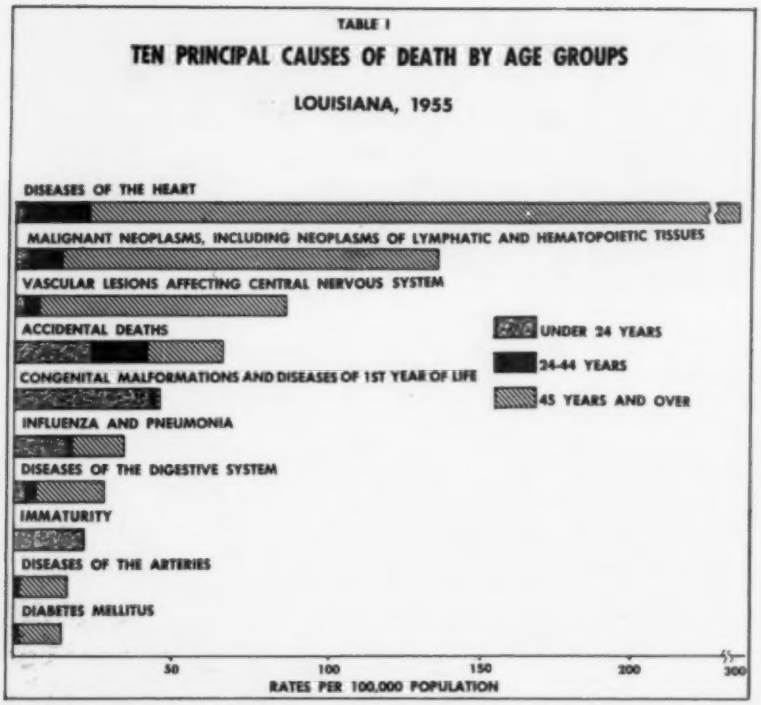


Chart showing the leading causes of death by age groups in Louisiana. Dotted bars indicate persons under 24 years; black bars indicate age 24-44, and cross bars indicate 45 years and over. Nearly 90 per cent of the deaths in the first three categories occur in persons over 45.

born and maintained in a germ-free environment have failed to show some of the usual changes associated with aging; some animal tissue cells, if maintained in an optimum nutritional medium and subcultured in a laboratory situation, continue to grow for an indefinite period. Everyone probably knows some rare individual who has defied the years.

As Dr. Charles Glen King has pointed out, good nutrition is certainly a lifetime job; in animals, it is known that several generations are necessary to evaluate the total effects of any diet. To complicate the situation a bit more, it has been demonstrated recently that a short-term mild dietary deficiency in an otherwise good diet occurring early in life may show no immediate ill effects but will cause damage when the animals are mature. In young rats maintained on an otherwise good diet, a short-term choline deficiency was reported to have caused degenerative changes in the liver, kidneys and arteries when the mature animals should have been at their peak of good health. Of course, people are not rats and it is unwise to get too far afield in speculating on the etiology of changes that seem to occur in old age.

Since we are discussing crises that occur in hospitals, consider the case of some older person in bed in a hospital awaiting surgery. What nutritional factors will improve or lessen his chances of getting well? The following seem to be among those that make a person a good or a poor operative risk:

1. The state of protein nutriture. (The literature reflects a general belief that a protein deficiency constitutes a hazard.)
2. The state of mineral and vitamin nutriture. (How often people are advised to raise their hemoglobin before an operation!)
3. The electrolyte balance.
4. The state of hydration or dehydration.
5. Overweight or underweight.
6. The habits of exercise. (Is a man who plays golf regularly a better operative risk than one whose major exercise is walking to the table?)

THINGS TO TEACH PATIENTS

Among other things, the surgeon checks these items; and within the limit of time left to him, he improves the nutritional status of his patient. In the hospital, he gives orders and his orders are carried out. But from the standpoint of the nurse, the patient's family, and the patient himself, is there not something fundamental to be taught about every one of these items? Each plays a part in maintaining good health. Once out of the hospital, keeping well is going to be largely the task of the patient and his family. No one will be standing by to give blood transfusions in order to raise the level of available nutrients. His fluid intake and output will not be measured in cubic centimeters and charted. There is much less chance that every meal will be fairly well balanced and that all meals will be served regularly so that the greatest good is likely to come from them. No nurse will be standing by to move him in bed often, to see that he sits up when he should, and that he moves and walks at the earliest possible moment because his metabolism is enhanced by proper exercise.

In teaching this individual patient, the nurse will consider not only the person himself, but she must consider his odds just as a race track professional would consider the odds before placing a bet. In this instance, it will be words not money that will be spent; but if the teacher be familiar with the vital statistics of the person's age group, the teaching is more likely to come out in front.

For instance, if the person is over 65 and is in a Louisiana hospital, he is one out of a 7 per cent segment of the state's population. This age group segment has increased 128 per cent since the 1900 census. If he was in the hospital in December 1956, the chances were 569 out of a thousand that he received old age assistance from the state department of public welfare. At 60 years of age, 28 persons out of a thousand are likely to be chronic invalids; at 70, there are 50 per thousand.

In the last half century, the causes of death have shifted from the mosquito to the automobile, from diseases like tuberculosis and typhoid to chronic ailments. The leading causes of death in Louisiana in 1955 are shown on page 108.

A breakdown of the figures shows that persons 45 years of age and over account for nearly 90 per cent of the deaths in the first three categories. (See Table 1 on this page.)

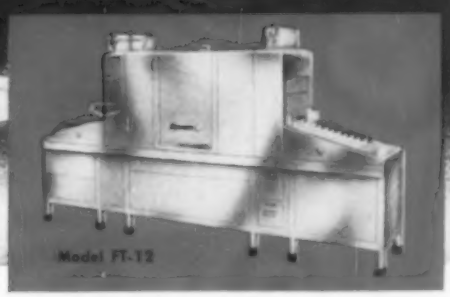
If these data mean anything, they mean that chronic diseases and not surgical procedures are the hazards, and that although the person in bed is a product of all his yesterdays, he will probably get well, but he should be taught some of the simple things that may contribute toward making the balance of his life healthier and happier. Much of this teaching should concern maintaining or bettering his nutritional status.

Consider the matter of fluid intake.

(*Continued on Page* 108)

You'll Sparkle too

with a Hobart Flight-Type



You'll sparkle as your dishes and sanitary standards sparkle — *and sparklingest of all will be your cost-per-serving figures!*

Amazingly fast, fully automatic, and continuous-racking, it's obvious that in these outstanding dishwashers human supervision and dish handling has been reduced to an absolute minimum. Yet with all of their speed and capacity, you get performance and dependability unequaled in dishwashing history—thanks to advanced, exclusive features coupled with the famed Hobart exclusive washing actions.

More—you can economically select a Hobart Flight-Type Dishwasher geared exactly to your volume requirements and available space. Model FT-12 fresh water scraps, power washes and rinses—all in 12 feet of space.

The Model FT-26 (illustrated) power scraps, power washes, power rinses and final rinses with additional time-for-drying. And between these two are many other models. Conveyor speeds can range from 5 to 12 ft. per minute.

If you have a smaller operation, there are many other Hobart automatic or semi-automatic models to choose from. Ask the advice of your local Hobart dealer. But if you're medium-sized and busy—or big—be sure to see the *Hobart Flight-Type*—the *only* dishwasher built with all stainless steel Flight-Type conveyors. A less expensive conveyor with nylon flight links is available. **The Hobart Manufacturing Co., Troy, Ohio.**

Trademark of Quality for over 60 years

Hobart machines

The World's Largest Manufacturer of Food, Kitchen and Dishwashing Machines

HOBART PRODUCTS

DISHWASHERS • DISH SCRAPPERS • GLASSWASHERS
DISPOSERS • PEELERS • MIXERS • FOOD CUTTERS
MEAT CHOPPERS • MEAT SAWS • TENDERIZERS
FOOD SLICERS • COFFEE MILLS • SCALES

It's **Hobart**...for Consolidated Planning, Purchasing and Servicing...*Kitchen-Wide!*

In the hospital room, the intake and output are probably being measured, charted and evaluated with great care. Could not these strange procedures and their importance be explained to the patient and his family? Could not the patient be reminded that he will need to take about 2 quarts of liquid each day when he gets home, and since he does not drink in terms of cubic centimeters and quarts, could not 6 to 8 ordinary glasses or cups be mentioned when the teaching is done? Perhaps, as age has crept up on this patient, he may have found it necessary to get up more often at night and deliberately have limited his fluid intake late in the day with no thought as to his total consumption. He might be told how much easier it is for the kidneys to do a good job if he drinks plenty of fluid. If he is like a third of the older population, constipation is a problem. Could he not be told that increased fluid intake sometimes helps? The chances are that no one has ever bothered to explain the principles to him. Perhaps he has no idea that 70 per cent of a normal adult body is water, that water is lost in breathing and in insensible perspiration as well as in the more obvious ways, and that these continuous losses must be compensated for by fluid intake every day. Just shaking a friendly finger at the patient and saying, "Drink more water," is not teaching.

If there has been a blood transfusion, it has been dramatic, and the patient and his family are going to make it a conversation item; of that, you can be sure. If by adequate laboratory tests and clinical observations, the patient had been judged protein deficient, a finding which is rather common in older people, how could this be related to the patient's personal eating habits? Which habits have been good and which have been bad? Can recommendations for gradual yet real changes be made in order to promote better health once the patient is out of the hospital? Has the patient noticed that his breakfast tray usually has one egg, a glass of milk? Does he know that the protein in the milk and in the egg is equivalent to that in 2 ounces of filet mignon? If he must eat in restaurants, it will be very important for him to know this, for in no other meal can he get better food for his money than at breakfast. And has anyone told him that protein of egg approaches 100 per cent usability whereas that of milk and meat are nearer 90 per cent; of peas, beans and cereals, in the neighborhood of 50 per cent?

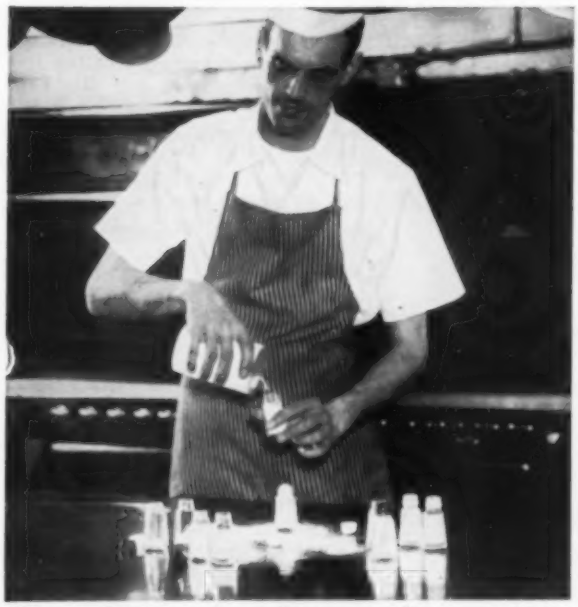
Most people will get some ideas about the adequacy of their protein intake from figures such as these. If a person is living on very little money, he should be taught that he can get more protein for his money in dried skim milk powder than in any other product on the market. Some thought might be given to persuading him to add a glass of milk to every meal. If he eats a high carbohydrate diet, this will be especially helpful and a glass of milk will go a long way toward making a balanced meal out of beans and rice. (*Cont. on p.* 110)

Leading Causes of Death in Louisiana, 1955

Cause	Rate*
1. Diseases of the heart	298.6
2. Malignant neoplasms	131.8
3. Vascular lesions affecting central nervous system	85.3
4. Accidental deaths	65.6
5. Congenital malformations	44.6
6. Influenza and pneumonia, all forms	35.0
7. Diseases of the digestive system	29.4
8. Immature birth	22.2
9. Diseases of arteries	16.6
10. Diabetes Mellitus	15.3

*Rates equal number of deaths per 100,000 population.

How Diamond Crystal seasoning packets end danger of cross-infection from dispensers



Old-type salt, pepper and sugar dispensers are often sources of infection. Require constant washing, sterilizing and servicing. Require storage space for both themselves and bulk seasonings.

Diamond Crystal packets are individual seasoning containers. They are disposable and sanitary. Need no servicing. And your patients appreciate their modern convenience.

Exclusive Diamond Crystal salt, pepper and sugar packets are hygienic. Save you money on labor and dispenser replacement

Old-fashioned seasoning dispensers can be an expensive problem to hospitals. They get dirty quickly. Shakers and bowls need constant cleaning. Re-filling. Sterilizing.

Considering the price of labor today, servicing several thousand shakers can really run up your operating costs.

Packets solve problem

Diamond Crystal seasoning packets are disposable. Hygienic. Eliminate dangers of cross-infection from dispensers.

Each packet contains a generous serving of either pure Diamond Crystal salt; spicy ground black pepper; or fine granulated sugar. When the patient finishes his meal, the packets are thrown away.

There is never the danger of broken glass dispensers when you serve packets.

Exclusive "shaker" action

Only Diamond Crystal packets let you *shake on* seasoning. Their sturdy fluted paper construction allows the same *method* of application as old-type dispensers—without the costly need of regular washing, filling and sterilizing. Your saving on dispenser servicing alone more than makes up for the slight additional cost of packets.

Exclusive "Shaker action" of Diamond Crystal packets allows controlled application of seasoning.

Send for free samples

See for yourself how Diamond Crystal packets can save you time and money. Just mail the coupon below. You will receive a free sample box of 100 Diamond Crystal salt, pepper and sugar packets for your own use by return mail.

Mail this coupon for free samples

Dept. MH.
Diamond Crystal Salt Co.
St. Clair, Michigan

Please send me a free sample box of your seasoning packets.

Name_____

Position_____

Hospital_____

Address_____

City_____ **State**_____

Suppose his dietary history indicates a calcium deficiency. Surveys indicate a negative calcium balance in many older people, and the great number of old people in hospitals with broken bones seems to support these findings. Should not the patient and his family be told how easy it is to add milk, or milk powder to cooked foods, and should not milk and milk products such as cheese be stressed as highly protective foods? Has anyone taught the easy trick of double strength milk: three tablespoonsful of milk powder stirred into a glass of ordinary milk, and there you have the daily quota for the average grown person. This mixture can be drunk as is, or flavored to suit the person's taste. Milk, however, does not have to be used as a beverage; about six tablespoonsful of powdered milk hidden in the day's food will serve the same purpose as two glasses of fluid milk. Turnip, mustard and collard greens are good but not very practical sources of calcium. Dark molasses is also good, but otherwise, calcium-rich foods are relatively few and far between in local diets unless milk in some form is used daily.

Suppose the dietary history indicates too much milk over a long period of time. Nutritional anemia may have developed because of poor iron intake. This often happens to people on ulcer diets or to people who live alone and do not like to cook. It may also happen to a person who has very irregular eating habits. Cannot the patient be told that the egg he eats for breakfast will also help raise his hemoglobin, that liver several times a week is fine if he likes and can afford it? Does he know that pork liver which costs 30 cents a pound has approximately 70 per cent more iron than the more expensive calves' liver?

If the patient is on a bland or a low-cost diet, be sure to remind him that there is one very common breakfast cereal that is so highly enriched with iron that a single serving will supply all the iron recommended for the daily intake for a normal adult. If he has no circulatory impairment, he may feel well with an 85 per cent hemoglobin; if impairment exists, he will feel better with 90 to 95 per cent hemoglobin.

Most nutrition and dietary surveys on older people point out that many diets contain too little ascorbic acid. If the person likes and can afford a good serving of citrus fruit, strawberries, canteloupe or watermelon every day, the problem is easily solved. All too often, however, "fruit juice" is mentioned as a daily must. The person recommending it means orange or grapefruit juice, but the person who follows this advice may go to the grocery store and buy pineapple, prune or apple juice, not knowing that pineapple juice has about a fifth as much ascorbic acid as orange juice, while apple and prune juices have mere traces.

VEGETABLES ARE CHEAPER

If the patient's money is in short supply and his food likes and dislikes are rigid, ascorbic acid recommendations may have to be met with vegetables. Again, greens, if properly cooked, are excellent. Raw cabbage, especially the core, and all members of the cabbage family are good; so are tomatoes and raw turnips. Weight for weight, bell pepper is more than twice as rich in ascorbic acid as an orange. It may take a food chopper to make these vegetables edible, but they are good sources of ascorbic acid. Usually old people have to be taught these relative values; such information was not a part of their education.

These are a few examples of approach and subject matter. The good nurse and the good physician can and

NEW Ideal COMBINATION

. . eliminates loose ends in CENTRAL FOOD SERVICE

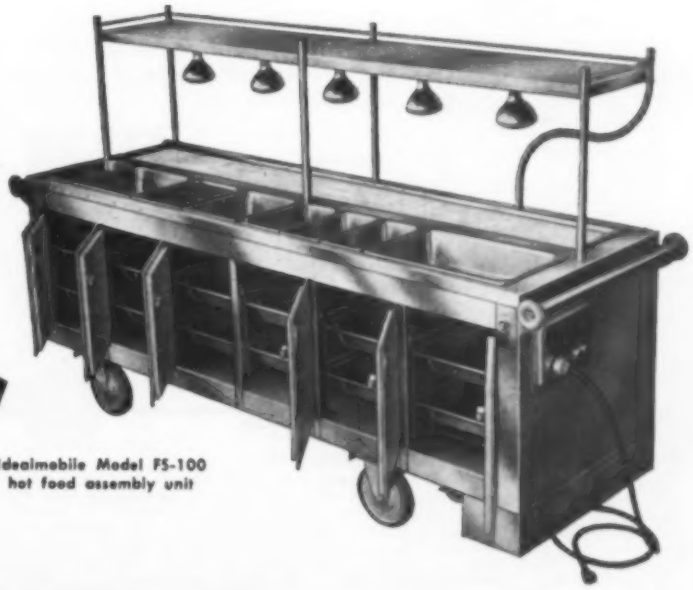
IDEAL Mealmobile, Model 9020-BCT with built-in beverage dispenser and mechanical refrigeration.

The new IDEAL Mealmobile with mechanical refrigeration and built-in beverage dispenser, together with the new Idealmobile, Model FS-100, hot food assembly unit, now make it possible for you to have a complete food service system that is thorough, fast and efficient.

The Mealmobile with its mechanical refrigeration, can now be used as a cold food storage unit. This permits the loading of salads and other cold items well in advance of food serving time and eliminates peaks and valleys in the work load in the kitchen. The new IDEAL Mealmobile in combination with the new Idealmobile hot food assembly unit, enables you to move foods directly from the hot food preparation area to the most convenient assembly area — thus speeding up food service.

The complete IDEAL centralized food service system introduces a cyclical operation in the movement of food from kitchen to patient . . . done the same way every time. And efficiency increases each time!

This IDEAL combination offers efficient centralized food service for all hospitals—regardless of size. Additional units may be added to meet your needs —present and future.



Idealmobile Model FS-100 hot food assembly unit

Write for assistance in your kitchen planning

Ideal® HOSPITAL EQUIPMENT
Found in Foremost Hospitals

Made only by the
SWARTZBAUGH MANUFACTURING COMPANY
MURFREESBORO, TENN.

will devise many more. Disease diets will be modifications of normal diets but teaching the patient to understand and follow them intelligently will require skill and patience. As for adapting a normal diet to an older person, perhaps the outstanding need is to include many highly protective foods because calorie needs have lessened and ability to use the food may also have lessened. Here are some good rules for patients to follow:

1. Adjust food intake to normal or desired weight. If this involves any great change, make it gradually.

2. Include plenty of milk, eggs, meat, nuts, and other protein-rich foods. Eat some of these at every meal.

3. Eat plenty of fruits and vegetables including green leafy or yellow vegetables along with some reliable source of ascorbic acid.

4. Be selective of carbohydrates; choose enriched or whole grain cereals. Eat only enough to maintain a proper weight. Try fruit or milk between meals instead of soft drinks and heavy sweets.

5. Avoid greasy foods and fried foods. Let the added dietary fats be mostly butter, margarine or salad dressings. As with carbohydrates, adjust the fat intake to maintain proper weight.

Eat regularly. Spacing daily food in three or even five small meals may have many advantages. Gorging on one large meal a day does not seem to be recommended by any authority.

Remember to drink plenty of fluids —and may some of it be milk.

Remember also that exercise in moderation is a part of a balanced pattern for better nutrition.

PHYSICIAN HAS GREAT INFLUENCE

In closing, let us turn to an analogy from physics. Teaching may be likened to a lever used to lift a sick person from his bed to a better state of health. The patient's family is nearest to the bed; they can exert some force but not much. (The person in the bed is their elder and better.) The nurse is next in line. With a few well chosen words, she can exert great force, but without a doubt the patient's doctor can exert the greatest force with the least effort. If his advice is clear and reasonable and if his dietary recommendations are as nearly as possible in line with the person's likes, the chances are great that the recommendations will be followed.

And if you want to know who is "old," Stieglitz says a person is old when he is 10 years the senior of the person speaking; so, by that definition nearly everyone needs better nutrition education.

Libbey Heat-Treated Safedge Glassware "is an important item in our economical service"

The Steak House, one of the four large dining rooms at Knott's Berry Farm.

KNOTT'S BERRY FARM
GHOST TOWN

Libbey Glass
Division of Owens-Illinois
Toledo 1, Ohio

Gentlemen:

Twenty-three years ago, on our opening day, we served 8 meals. Today we cater to almost 38,000 diners per week, and can seat 1750 people at one time.

In an operation of our size, all tableware items see a great deal of service and must be durable as well as attractive. Libbey's Heat-Treated Safedge Tumbler looks nice on our tables and is extremely durable.

We are well satisfied with Libbey Glassware and feel that it is an important item in our economical service.

Sincerely yours,

Walter Knott

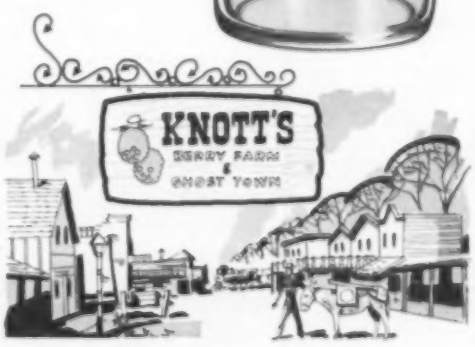
Located 22 miles from Los Angeles, Knott's Berry Farm is one of the largest and most popular eating places in the Southwest. There are restaurant facilities for 1750 people, 33 intriguing shops, a Ghost Town, Gold Mine, and many reminders of early life in Southern California.

Libbey Heat-Treated Safedge Glassware provides complete water service in all four dining rooms at Knott's Berry Farm. The pleasing appearance of the glassware, and its extreme durability contribute towards the successful operation and development of this famous eating place.

For every operation, whether large or small, Libbey Heat-Treated Glassware provides attractive, durable and economical service. Audit checks made in seven leading restaurants showed the average number of servings per tumbler ranged from 739 to 3700, at a per thousand serving cost of 8.8 and 1.8 cents respectively. And every glass is backed by the famous Libbey guarantee: "A new glass if the rim of a Libbey 'Safedge' glass ever chips."

Learn how Libbey Heat-Treated Safedge Glassware can help reduce your own operating costs. See your Libbey Supply Dealer, or write to Libbey Glass, Division of Owens-Illinois, Toledo 1, Ohio.

Water Tumbler
HT No. 610
9½ oz.



LIBBEY SAFEDGE GLASSWARE
AN (I) PRODUCT

OWENS-ILLINOIS
GENERAL OFFICES · TOLEDO 1, OHIO

Menus for March 1958

Virginia Rine
Head Dietitian
Yakima Valley Memorial Hospital
Yakima, Wash.

1 Blended Juice Scrambled Eggs • Braised Beef Cubes Buttered Noodles Sliced Beets, Harvard Sauce Sunset Salad Tapioca Cream • Consommé Creamed Turkey on Toast Points Adirondack Salad Cranberry Cocktail Assorted Cookies	**2** Sliced Oranges Muffins and Jam • Roast Pork, Gravy Snowflake Potatoes Asparagus Spears Cinnamon Apple Ring Angel Food Cake • Minestrone Spaghetti With Meat Sauce Romaine With Romaine Dressing Toasted French Bread Whole Peeled Apricots	**3** Tomato Juice Shirred Eggs • Swedish Meat Balls Baked Potato Mixed Vegetables Pear Halves, Date Filling Strawberry Bavarian • Cream of Potato Soup Mushroom Soufflé Cut Green Beans Fruit Punch Nut Delights	**4** Stewed Prunes Poached Eggs • Breaded Veal Cutlet au Gratin Potatoes Broccoli, Lemon Butter Perfection Salad Date Torte • Cream of Pea Soup Creamed Ham on Baking Powder Biscuits Pineapple, Cherry Salad Rainbow Sherbet	**5** Orange Juice French Toast, Sirup • Broiled Liver Patties Tomato Sauce Diced Potatoes Whole Kernel Corn Lettuce Wedge, 1000 Island Dressing Peach Upsidedown Cake • Vegetable Soup Macaroni and Cheese Chopped Spinach Loganberry Nectar Butterscotch Squares	**6** Apple Juice Soft Cooked Egg • Roast Sirloin of Beef Whipped Potatoes Beets Julienne Grapefruit Sections, Lettuce Baked Cherry Pudding • French Onion Soup Meat Roll and Gravy Mixed Green Salad, Blue Cheese Dressing Brownies, Ice Cream
7 Sliced Bananas Scrambled Eggs • Grilled Halibut, Tartare Sauce Parsley Potatoes Buttered Carrots Green Pepper Slaw Lemon Meringue Pie • Oyster Stew Egg Salad Sandwiches on Whole Wheat Bread Shoestring Potatoes Stuffed Celery Sticks Fruit Cup	**8** Applesauce Poached Eggs • Veal Birds French Baked Potato Escalloped Tomatoes Head Lettuce, Sweet and Sour Dressing Spice Cake, Burnt Sugar Frosting • Italian Consommé Vegetable Beef Hash Cornbread and Honey Prune and Cottage Cheese Salad Whipped Gelatin	**9** Orange Juice Sweet Rolls, Bacon • Chicken à la Maryland Whipped Potatoes Buttered Peas Molded Fruit Salad Cream Puffs • Potato Chowder Cheese Fondue Creamed Green Beans Mandarin Orange, Pineapple Salad Macaroons	**10** Grapefruit Juice Hot Cakes, Sirup • Lamb Patties Steamed Rice Creamed Asparagus Spiced Apricots on Lettuce Cheesecake • Julienne Soup Creamed Chipped Beef on Baked Potato Carrot Coins Lettuce Wedge, 1000 Island Dressing Dark Sweet Cherries	**11** Tangerine Juice Scrambled Eggs • Baked Pork Chops Escalloped Potatoes Mexican Corn Apple, Celery, Nut Salad Chocolate Marshmallow Pudding • Cream of Mushroom Soup Chicken Finale Chopped Broccoli Stuffed Pear Halves on Lettuce Cranberry Crunch	**12** Apricot-Pineapple Juice Poached Eggs • Spaghetti, Meat Balls Buttered Lima Beans Tossed Salad, Italian Dressing Hard Rolls White Cake With Fluffy Icing • Cream of Pea Soup Toasted Cube Steak Sandwich Shoestring Potatoes Grated Carrot and Raisin Salad Strawberry Ice Cream
13 Prune Juice Coffee Cake, Bacon • Pot Roast of Beef Oven Browned Potatoes Paprika Cauliflower Fruit Salad With Fruit Dressing Coconut Cream Pie • Creole Soup Egg Cutlets With Cream Sauce Asparagus and Pimiento Salad Lemonade Oatmeal Bars	**14** Grape Juice Soft Cooked Eggs • Salmon Loaf, Lemon Baked Potatoes Buttered Spinach Celery Curls, Olives Graham Cracker Delight • Vegetable Soup Macaroni, Tomato and Cheese Casserole Seasoned Green Beans Citrus Section Salad Jelly Roll	**15** Orange Juice Scrambled Eggs • Sirloin Tips, Gravy Mashed Potatoes Glazed Carrots Banana Nut Salad Baked Custard With Caramel Sauce • Cream of Potato Soup Ham Soufflé Buttered Asparagus Blackberry Nectar Peach Marlowe	**16** Grapefruit Sections Canadian Bacon • Pounded Dinner Steak Stuffed Baked Potato Sliced Beets Head Lettuce With French Dressing Boysenberry Cobbler • Cream of Mushroom Soup Chicken Salad Sandwich Potato Chips Cottage Cheese and Bing Cherry Salad Assorted Cupcakes	**17** Blended Juice Soft Cooked Eggs • Roast Leg of Lamb, Mint Jelly Parsley Potatoes Broccoli, Drawn Butter Minted Pears Shamrock Ice Cream • Cream of Corn Soup Link Sausage With Country Gravy Candied Sweet Potato Fruit Salad With Gelatin Garnish Rice Pudding, Raisins	**18** Tomato Juice Sweet Rolls • Baby Beef Liver, Bacon Baked Potato Peas in Cream Grapefruit, Apple Salad Pumpkin Chiffon • Consommé Creamed Veal Cubes Buttered Noodles Carrot, Celery Sticks Plum Sauce
19 Orange Juice Poached Eggs • Mock Drumsticks Whipped Potatoes Wax Beans With Pimiento Lettuce Wedge, Roquefort Dressing Cherry Pie • Cream of Vegetable Soup Asparagus Spears on Toast, Cheese Sauce Grape Punch Lime Sherbet Ginger Cookies	**20** Sliced Bananas Scrambled Eggs • Old-Fashioned Beef Stew Baking Powder Biscuits, Honey Pickled Beet Salad Vanilla Pudding • Cream of Spinach Soup Grilled Hamburgers on Toasted Buns Shredded Lettuce, Pickles, Relish, Ketchup Chilled Tomato Juice Apricot Crisp	**21** Grapefruit Juice Muffins and Jam • Shrimp Creole Steamed Rice Baby Lima Beans Spiced Peaches Ambrosia • Cream of Celery Soup Tuna Fish Soufflé With Cream Sauce Cooked Vegetable Salad Sunshine Cake With Orange Icing	**22** Orange Juice Poached Eggs • Turkey Mushroom Pie With Cornbread Topping Buttered Asparagus Peach and Olive Salad Rainbow Gelatin Cubes • Consommé, Croutons Curried Veal Baked Potatoes Marinated Bean and Onion Salad Fruit Cocktail Pudding	**23** Apple Juice Coffee Cake, Bacon • Baked Ham With Mustard Glaze Mashed Potatoes Buttered Peas Perfection Salad Pineapple Sundae • Cream of Chicken Soup Grilled Cheese Sandwich Shoestring Potatoes Mixed Pickles on Lettuce Frosted Brownies	**24** Apricots Raisin Nut Rolls • Cube Steaks Hashed Brown Potatoes Buttered Mixed Vegetables Lettuce Wedge With Sweet and Sour Dressing Butterscotch Pie • Cream of Tomato Soup Potato Omelet Crisp Bacon Grated Cheese on Spiced Pears White Cake With White Mountain Icing
25 Orange Juice Scrambled Eggs • Cheeseburger Loaf Potato Puffs French Green Beans Fruit Gelatin Salad Date Torte • Vegetable Soup Chipped Beef and Macaroni Casserole Sliced Beet and Egg Salad Apple Crisp	**26** Citrus Sections Poached Eggs, Muffins • Rolled Beef Roast, Gravy Paprika Potatoes Whole Kernel Corn Chopped Lettuce With French Dressing Bread Pudding, Hard Sauce • Cream of Celery Soup Spanish Rice Buttered Spinach Pineapple Rings, Cherry Garnish Lime Sherbet	**27** Grape Juice Soft Cooked Eggs • Pork Chow Mein Crisp Chinese Noodles Lima Beans Mandarin Oranges on Endive Sponge Cake • Bouillon Chicken Dinner Sandwich Whole Green Beans Tossed Vegetable Salad, Oil and Vinegar Peach Halves	**28** Blended Juice Poached Eggs • Salmon Steak With Lemon Wedge Stuffed Baked Potato Asparagus Spears Green Pepper Slaw Cream Puffs • Cream of Mushroom Soup Hot Deviled Eggs on Toast Under the Sea Salad Tomato Juice Chocolate Chip Cookies	**29** Prune Juice Scrambled Eggs • Chopped Beef Patties French Baked Potato Buttered Beets Grapefruit Wedges on Lettuce Tapioca Fluff • Cream of Tomato Soup Escalloped Potatoes and Ham Cooked Vegetable Salad Pineapple Juice Whole Peeled Apricots	**30** Sliced Bananas Bacon Strips • Roast Tom Turkey Sage or Giblet Dressing Mashed Sweet Potatoes Celery Sticks, Olives Confetti Angel Food Cake • Cream of Split Pea Soup Broiled Luncheon Meats Potato Cheese Puffs Stuffed Prune Salad Fruit Gelatin With Custard Sauce

31 Grapefruit Juice, French Toast, Sirup • Swiss Liver, Creamed Potatoes, Carrot Slices, Mixed Green Salad, French Dressing, Gingerbread With Whipped Cream • Cream of Spinach Soup, Tamale Pie, Hard Rolls and Butter, Fruit Cup, Assorted Cookies.

Ready-to-eat or cooked cereals served on all breakfast menus.

Don't throw money away on broken dishes!

A west coast restaurant using ordinary china had replacement costs totaling $216,376 for a seven-year period . . . $30,911 a year. Then the owner changed to PMC melamine dinnerware.

Saved . . . over 50% a year!

For an equal seven-year period replacement costs, *including the original investment in PMC dinnerware,* were only $106,581 . . . a savings of $15,685 a year. (Name on request)

You can solve your breakage problem with

De Luxe REGAL WARE

Here's new beauty and strength . . . strength that makes this melamine dinnerware hard to chip, crack or break. De Luxe Regal Ware is made by an exclusive "color-on-color" process of bonding two colors into a single piece. Each piece has the self-draining contour base and heavy duty rolled edges. For more information about money-saving De Luxe Regal Ware, write:

PLASTICS MANUFACTURING CO. • 825 Trunk Ave. • Dallas, Texas

COLORS:

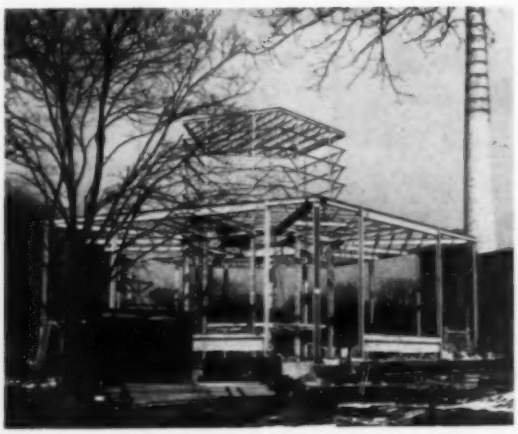
Banded on Tan — Sepia; Banded on White — Burgundy, Bermuda Coral, Sage Green.

Also available in solid and textured colors, and in decorated patterns.

A Pentagon Solved This Heating Problem

A five-sided building houses five boilers and all auxiliary equipment without crowding or waste space and cost less to build than a conventional structure

WILLIAM BRENIZER



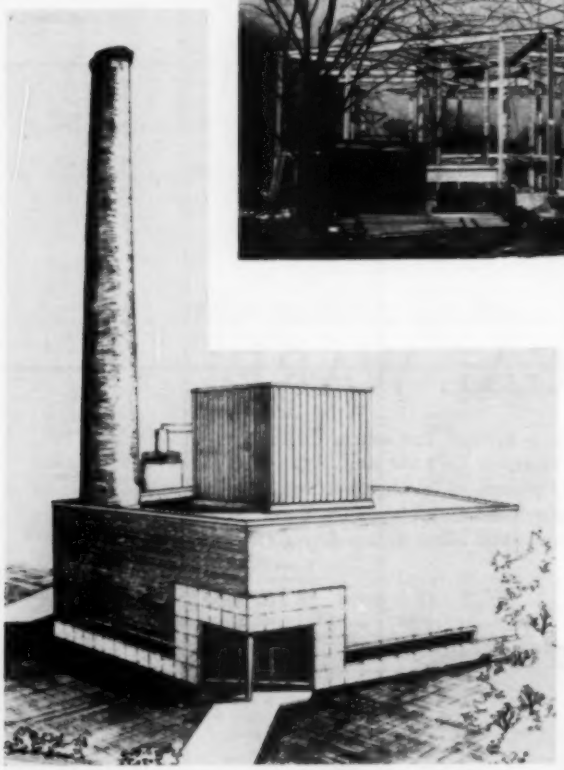
Right: Steel structural framework of new power plant at Richmond State Hospital.

SEVERAL years ago, following a mid-December breakdown of the three-boiler system at Richmond State Hospital, Richmond, Ind., and the consequent loss of electricity, water and heat, plans were started for a new steam generating plant.

In November 1954, the firm of Fleck, Quebe and Reid, Indianapolis, was chosen to draw plans and write specifications for the new plant. They retained the services, on a consulting basis, of Frederick B. Morse, professional engineer of Lafayette, Ind.

The heating load, steam demands, and hot water requirements for the in-

Mr. Brenizer is business administrator, Richmond State Hospital, Richmond, Ind.



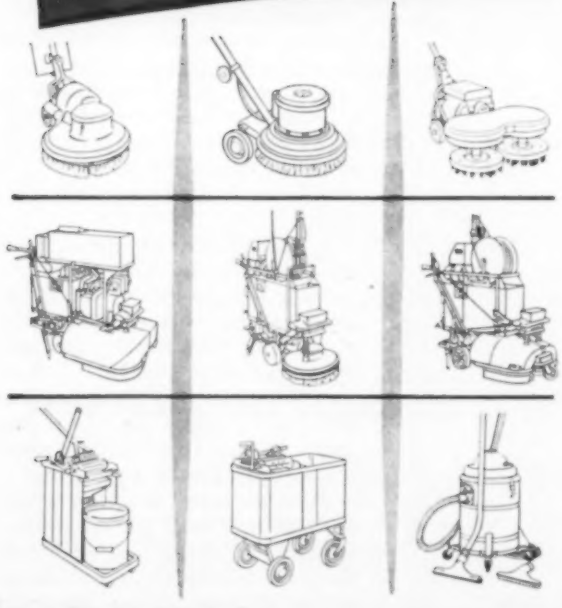
Above: Rendering of the five-sided power plant at the hospital, showing the modern appearance of the structure. Substantial savings in construction cost were achieved by use of this type of building. Right: Floor plan of power plant indicates the location of future boilers. Auxiliary equipment, such as feed water heater, water softeners, switch gear, and so on, is placed in spaces between boilers. A vacuum cleaning system with 23 outlets is also provided.

Keep your floor-maintenance men happy . . .

with *Job-Fitted* EQUIPMENT!

Choose from the COMPLETE *Finnell* Line

More than a score of models and sizes permits selection of the equipment that's exactly right for your job!



However much a maintenance man may want to do a good job, and at the same time show savings in labor costs, he's *stymied* if the machine is too small, or too large, or is otherwise unsuited to the job. Different floors and areas call for different care and equipment. That's why *Finnell makes more than a score of floor-maintenance machines.* From this complete line, it is possible to choose equipment that is correct in size as well as model . . . that provides the maximum brush coverage consistent with the area and arrangement of the floors.

Finnell offers *Conventional Polishing-Scrubbing Machines* in both concentrated and divided-weight types, each in a full range of sizes . . . a *Dry-Scrubber,* with self-sharpening brushes, for cleaning grease-caked floors . . . *Combination Scrubber-Vac Machines* for small, vast, and intermediate operations, including self-powered as well as electric models . . . *Mop Trucks* . . . a *Wet and Dry Vacuum Cleaner,* in baked enamel or stainless steel, with 1½ hp By-Pass Motor. In addition, *Finnell* offers a full line of fast-acting *Cleansers* for machine-scrubbing . . . *Sealers* and *Waxes* of every requisite type . . . *Steel-Wool Pads* and other accessories – *everything for floor care!*

In keeping with the *Finnell* policy of rendering an individualized service, *Finnell maintains a nation-wide staff of floor specialists and engineers. There's a Finnell man near you* to help solve your particular floor-maintenance problems . . . to train your operators in the proper use of *Finnell Job-Fitted Equipment and Supplies* . . . and to make periodic check-ups. For consultation, demonstration, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1402 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

FINNELL SYSTEM, INC.

Originators of Power Scrubbing and Polishing Machines

Everything FINNELL for Floor Care

BRANCHES IN ALL PRINCIPAL CITIES

stitution, which has 1700 patients and 500 employes, were calculated as to present and future need.

The ultimate total steam demand was estimated at 125,000 pounds per hour. Based on the ratio of summer and winter loads, a boiler size of 35,000 pounds per hour was selected. For the ultimate plant, including future expansion of facilities, five such boilers would give a firm capacity of 140,000 pounds per hour.

The desired location for the building presented a question of adequate space. A search of technical literature failed to disclose any deviation from a rectangular or square shape for a power plant. A circular building would yield more floor area for a given perimeter than would any other building shape.

FIVE SIDES SOLVE PROBLEMS

What would happen in a circular plant with the chimney extending from the center? How could the interior coal handling be accomplished? If all the boilers were faced toward the center of the building, how would it complicate the disposal of fuel gas? These and many other problems were solved. Only a little imagination was required to see that a five-sided building was the answer. All corners could be efficiently used. Auxiliary equipment, such as feedwater heater, water softeners, switch gear, and so on, was located in space between the boilers.

A modern plant must be easy to maintain. To facilitate quick repairs with a minimum of spare parts, specifications required that all valves and traps be made by the same manufacturer.

A vacuum cleaning system, with 23 outlets located throughout the building, was provided so that operating personnel could easily keep the plant clean. Most power plants have a large number of glass lights high on the wall, making replacement and cleaning a problem. To remedy this, only a vision strip at eye level above the operating floor was provided.

These plans and specifications, radically different from the conventional power plant design, proved beyond doubt the substantial construction cost savings as compared to a rectangular or square building of the same floor area and height.

Construction began in June 1956 and the contractors assured us that our new "Indiana Pentagon" would be in operation by January 1958.

New!

The most efficient – most economical way to prepare syringes for autoclaving!

WECKINK STERILIZING BAGS

printing turns **GREEN** *when autoclaved*

Only WECKINK Bags offer you these many exclusive advantages!

- **Proof of Autoclaving – the printing turns green when autoclaved – your guarantee that the contents have been through the autoclave.**
- **Water Resistant Glue – bag will not come apart during or after autoclaving.**
- **Complete Steam Penetration – the special paper used in WECKINK Bags has the precise degree of porosity to assure thorough steam saturation of the contents.**
- **Wet Strength Paper – that resists tearing when wet.**
- **Three convenient sizes at low, low prices (see below).**

WECKINK STERILIZING BAGS

1,000	10,000	20,000	50,000
#56-404 – 6" long for 2 and 5 cc syringes			
$6.50	$6.25	$5.75	$5.40
#56-408 – 8" long for 10 and 20 cc syringes			
$7.40	$7.15	$6.65	$6.30
#56-412 – 10" long for 30 and 50 cc syringes			
$9.35	$9.05	$8.55	$8.20

Save money on contract orders of 60,000 or more!

SEND FOR A FREE SAMPLE of the WECKINK Sterilizing Bag! Just write to Weck.

Weckink Sterilizing Bags are only part of the complete Weck System which revolutionizes the procedure of preparing items for autoclaving. The Weck FOLDISPENSER, (shown at right) which folds the WECKINK Bag at the same time that it dispenses the Weck Autoclave Tape for sealing, is another integral part of this new system. *For complete information, just write to Edward Weck & Co., Inc., 135 Johnson St., Bklyn. 1, N. Y.*

WECK 68 years of knowing how

MANUFACTURERS OF SURGICAL INSTRUMENTS • HOSPITAL SUPPLIES • INSTRUMENT REPAIRING

A Training Program for Housekeepers

11. Supervision Is the Executive's Primary Job

BARBARA D. MILLS

THROUGHOUT the training program you have been taught certain technics of leading and guiding people. In fact, good human relations has become one of your most outstanding qualifications. Your behavior as a prospective administrative housekeeper has been scientifically investigated and directed, with a new emphasis on the importance of supervision.

However, I have found that each of you has a tendency to shy away from disciplinary actions. At this point, you should be careful not to confuse good intentions with a mere desire to have people like you, rather than respect you. If you do, you will find yourself giving way to an individual's demands rather than hurt his feelings.

UPHOLD YOUR POLICIES

The most sensible solution is to clarify and uphold your organizational and departmental policies and procedures. Any other type of leadership will result in demands becoming too big and too frequent to cope with; *then* you will realize there are wiser principles of leadership by which to handle these problems. But in the meantime you have developed a definite dislike, the individual has become a nuisance, and, by the same token, he is right back where he started—he is insecure.

I grant you that it is a great lift to realize that people are dependent on you to lead and guide them, but, on the other hand, satisfaction should come in a person's growth, not in keeping him dependent on you.

I should like to give you some "guideposts" on this subject of supervision. Supervision is an essential management tool, and without it the best employes are ineffective, uncoordinated and unhappy. Therefore, don't avoid the problems of the day by working on routine details, but allot the majority of your time to supervisory work, other than paper work. You will soon find that there is no percentage in any other type of operation, because production and morale are higher when supervision is maintained at the highest level.

People like and want good supervision and leadership. By that, I mean democratic leadership, whereby people are made to feel that they are a part, that their contribution means something, and that they have an opportunity to participate and work as a team.

In many instances this will mean that you must push back the old horizons: Relinquish your authority, instead of pulling your rank; be a balance wheel, rather than a supervisor or superior. This kind of relationship and understanding makes you approachable and will overcome the idea among your personnel that the only *upward* means of communication in your department is the elevator.

People will stop behaving like petty tyrants when you give them an opportunity to share in responsibility. Most people like to work, and giving them responsibility to act responsibly usually results in spontaneous cooperation. However, don't forget to respect their ability to grow and adapt to changes. Stop nurse-maiding and spoon-feeding your personnel.

WORKING WITH PEOPLE

The majority of situations that confront this department, and which at times are permitted to become problems, consist of negotiations with other people. You have heard me say many times that the biggest part of your job is salesmanship—it's your business—and as you have learned and *now* realize, it never stops. To be successful in an endeavor means bringing the negotiation to an end that is satisfactory to both parties. The outcome, whether you are employing someone or seeking a position yourself, is a matter of negotiation.

By now, of course, you realize it is far more important to know how to prevent a situation than it is to overcome the situation after it has developed. When bad situations occur, the fault belongs to those who allowed it to happen. As a leader you are better conditioned to handle such problems and should be able to see them in a way that allows you to "blow to bits" the beginning trouble.

As a rule, trouble occurs because someone did not listen or has gotten his information from the wrong channel, and his misunderstanding has jelled into actual fact. You will find that these situations usually are trifling affairs, but nevertheless you must put forth every effort to unravel the problem.

Get it out in the open by bringing it up at a group discussion meeting. This is most effective, because everyone then is alerted to the situation and can help you as time goes on. Also, this type of meeting is an ex-

This is the eleventh lecture on training executive housekeepers in the series begun in the March 1957 issue of The MODERN HOSPITAL. The course was prepared by Mrs. Mills while she was director of housekeeping services at St. Luke's Hospital, Chicago. She is now director of housekeeping services at Allegheny General Hospital, Pittsburgh.

cellent place to communicate with your personnel. At these meetings you can uncover the problems that carry the infection that spreads. Employes need a place to let off steam with complaints, concern or just griping, and if you will make it a point to get the co-workers relaxed to the place where they will start feeding in the problems, they are no longer problems.

Remember, nine out of 10 problems will be the principal point of discussion facing the department as a whole. Here you can tear the cover off and see what is wrong. It also gives an opportunity for an expression of loyalty to the department and yourself.

Be sure not to sit back and relax because of the source of your information. Do something about it right then and there: Evaluate, criticize, create incentive for their ideas toward achieving results.

Your responsibilities look something like this: to know what is, to understand what should be, and to inspire others to make a full contribution to reach the goal. This requires sound vision, the ability to look ahead and to set up additional goals to be reached at varying intervals. This is proper preplanning. You must know where you want to go and how to get there.

However, all this is valueless unless we develop the ability to inspire others to contribute toward the desired goal. Unfortunately, there are too many people in executive positions who seem to lead on the assumption that their function is merely to tell others what to do. They do nothing themselves, but stand ready and waiting to administer a bawling out when they fail to get full results.

A good executive gives something to every person for whom he is responsible. He should play the part of a roving back in a football game; he should be there to throw his weight wherever it is needed. No doubt you will like your employes, but do you plan to give them the calm and solid affection they need for the difficult climb to maturity? Or do you plan to start them out with a grave handicap, *i.e.* with you continuing to be the expert and never letting them grow up?

If you occupy the lead position the compensation is greater than that of those under you. Therefore, you are presumed to have superior qualities of experience and judgment which you should share with those whose operations you direct in a way they can accept and utilize. Otherwise you are starving the department.

People are your chief responsibility and concern. You as an individual know the limit of your authority in assuming responsibility for them. Regardless of what weakness your subordinates may have, if they are good enough to be retained, you should join your strength to theirs, so that together you form a partnership of strength to achieve the desired goal.

What are you doing about sharing what you have learned? It is impossible to lead from the rear. Some things can be done by issuing managerial edicts, but most things have to be accomplished by solid work in which the executive gives and gives of his own patience, experience and inspiration. To direct people to "go ahead" can never obtain the same results as "come on."

THEY DO AS YOU DO

Remember, as a general rule subordinates will do as you do, other than what you tell them to do. Strive to establish high morale; this gives a sense of importance that dollars in their pockets don't give. I have found that it radiates like a light inside, giving off warmth and friendliness. Enthusiasm does that for us, and is helpful in achieving real happiness by teaching us that happiness is an investment within ourselves. We do not live long before we realize it helps to receive appreciation. Gratitude lubricates labor and is absolutely essential to well-being.

To give you some ideas on handling personnel, let's take a cross section of personalities and their behavior problems. I will give each of you a card; on it is described a situation that I want you to develop by rôle playing. Put on the back of the card one or two words that bear relation to your ideas and will identify the sequence of your thinking.

1. Co-worker seemingly is content with his position, but leaves without notice to take a job elsewhere.

Since there are many reasons for turnover we should strive for reasonable ways to keep people with us; the chief concern should be *why* the employe left, rather than the fact that his departure has left the department shorthanded. What was wrong in the screening process when I hired the individual? Did I give a poor evaluation of personality and capabilities? Request an exit interview and by questioning find out where the trouble lies. What happened? Did we fail to offer security? Did he quit because he was treated unfairly? Did we fail to give him recognition for an individual achievement or a job well done —either financially or by a pat on the back? Did his capabilities deserve a reevaluation of the job title, or consideration of advancement?

2. Employe is a bad actor; he has repeatedly been indifferent to warnings regarding his conduct.

Criticism has been required, but how was it administered? Be careful not to let your own desire to punish become a part in making the individual a problem. Be sure the person understands his own errors. Question the employe, don't talk. Try to change his attitude by questioning. Can you interpret feeling or attitude expressed by behavior? Can it be his background? Why does he find it so important to defy the principles of unity? Suggest that he start to learn the trade and forget the tricks. To be important, a warning need not be eternal; it should not be given in the form of a threat, but it should have a time limit. If he continues to be unwilling to understand, it will be necessary to dismiss him. Results will be either compliance or continued defiance.

3. Worker with top rating becomes slipshod in procedures, appearance, attendance and/or attitude.

A fairly basic way to start improving this situation is to discover its cause. This also is a good time to find out what makes the employe tick. Are we filling his needs? People tire of routine; give the employe a new perspective. Do the inevitable anxieties exist? Most people do not remain unresponsive to sincere interest vested in them and their problems. Follow through until he is again on solid ground.

4. Co-worker has difficulty getting along with personnel of other departments. He is a chronic complainer.

This condition develops from many things. Is the person timid? If so, he could be unsure of himself, limiting his mental attitude because he is so busy thinking about himself. You should try to point out that the enemy is not outside or in someone else, but in his own thinking. Are his complaints justified? People like fair treatment, and it takes less effort to be courteous than to be rude. Perhaps there is not enough interest in the job to create an incentive to improve. Has he been given the work for which he is best suited? Perhaps he has been so busy defending his own ego that he has not listened to what we have been trying to teach him. This answer must be in one of these factors, but if not I would tackle the problem from another angle before resorting to firing him.

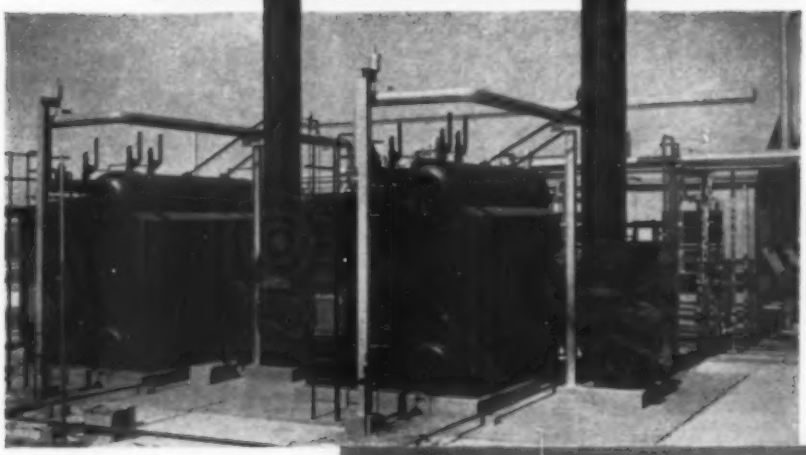
5. Worker has excellent potential for leadership, but absenteeism hinders his advancement.

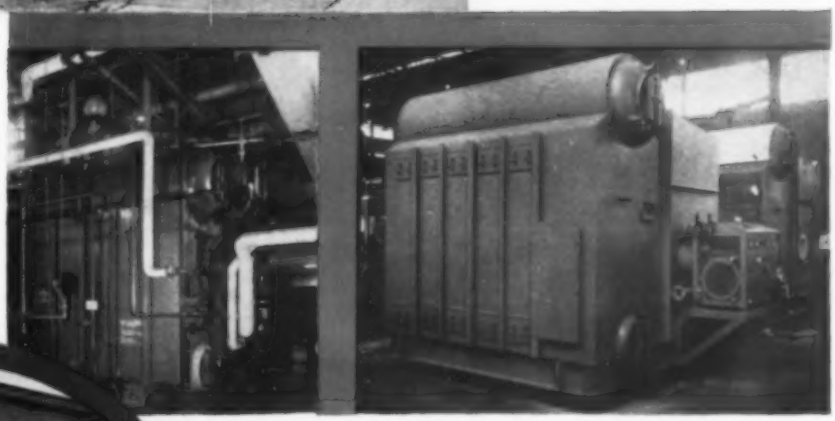
Usually an employe with an objective is a better employe. Try to create a challenge in his work. If his home life is a factor, can it be remedied? Does he wish to be helped, or is he satisfied with his present situation? Try to change his attitude by giving him a new approach to the situation.

Vogt

Package

STEAM BOILERS *give* versatility with economy

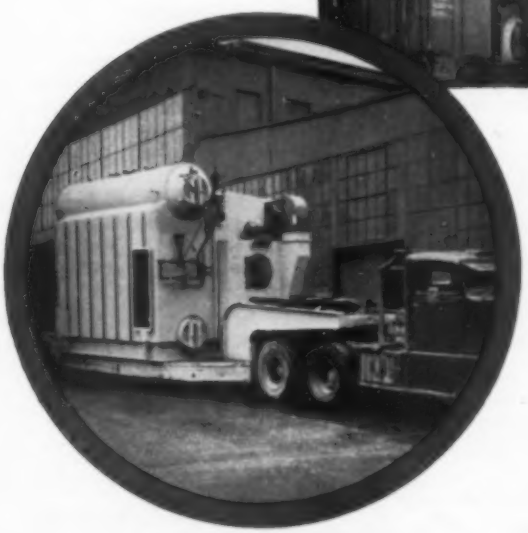




Above: Two units serve a gas pipeline company.

Left: Installation in fibre box-board plant.

Right: Unit for a leading soap manufacturer.



Enroute to an office building.

FOR POWER, PROCESS OR HEATING

Available in capacities from 10,000 to 50,000 pounds steam per hour in three standard pressures of 175, 250 and 375 pounds per square inch gage, factory assembled.

Write for Bulletin PSG-2, Dept. 24A-BMH

HENRY VOGT MACHINE COMPANY, Louisville, Ky.

SALES OFFICES: New York, Chicago, Cleveland, Dallas, Camden, N. J., St. Louis, Charleston, W. Va., Cincinnati.

OTHER VOGT PRODUCTS:

DROP FORGED STEEL VALVES, FITTINGS, FLANGES AND UNIONS
PETROLEUM REFINERY AND CHEMICAL PLANT EQUIPMENT
HEAT EXCHANGERS • ICE MAKING & REFRIGERATING EQUIPMENT

Hospital Income Will Come From Everybody

(*Continued From Page* 54)
pitalization—usually insured through Blue Cross. These direct service plans now serve only about 4 million persons, but they are likely to increase during the next few years. Such growth will bring demands for cooperation upon hospitals, directly or through Blue Cross.

Well people have a fourth major line of choice. They can turn to government — local, state, national. Through their political demands upon Congress, they might cause health insurance to be required by law—for everybody or for specified groups of persons. The health insurance fund thus accumulated could be expended through voluntary plans like Blue Cross as well as through direct dealings with hospitals and doctors.

Well people might also push other lines of governmental action, for instance, the use of general tax revenues, especially from state and local governments, for the support of general hospitals or of hospitals and nursing homes providing long-term care.

Let us be sure of one thing: The ultimate responsibility for satisfying people concerning hospital care does not fall upon Blue Cross or any other insurance plan. This responsibility falls upon the hospitals. Hospitals must satisfy those who support them.

By or before 1975, the people who support the hospitals will be almost everybody, for almost everybody will then be paying for their hospitalization costs directly out of their pockets on a budgeted basis; or negotiating the money from their employers through collective bargaining, in lieu of a cash wage increase, or obtaining all or part of the money from social security or general tax funds, through their political weight.

How to satisfy people? How to make friends and influence people—the people who support you? There is a principle to guide us—the principle of participation. Hospitals have always accepted a profound obligation of service to their patients, but these patients, being sick persons, cannot currently and continually participate in the hospital enterprise. Yet how can thousands or millions of well people — potential patients — be made partners?

The practical answer is that a large proportion of these millions belong to and function through organized groups, and that you must bring representatives from some of these groups into systematic relations with your hospital. In obtaining "representatives," unilateral selection by either side will not be as effective as a selection which has been the subject of informal consultation and is the outcome of a consensus of feeling.

What groups are important, and for what purposes? First, consider the matter of financing. Your current income in 1975 will come mainly from insurance funds and tax funds. The groups most concerned with voluntary insurance funds will be, in industrial communities, labor unions and employers. From this point of view, the significant employers are those whose firms have many insured persons among their employes. Sometimes there are also fraternal or social groups which are the base of locally important insurance funds.

FUNDAMENTAL PRINCIPLE

Here we come to another principle which is perhaps the foundation of the future financing of hospitals. A nonprofit agency is in a secure and stable position only when its policy-determining body is well related to

NOW! A GENERAL PURPOSE GERMICIDE

WESCODYNE® is an excellent detergent as well as a powerful disinfectant. Provides amazing cleaning action as it disinfects. A time and labor saver. Yet cost is less than 2¢ a gallon at the general-purpose use dilution of 75 ppm available iodine.

WESCODYNE is the single hospital germicide suitable for disinfecting and sterilization procedures in all hospital areas. It is nonselective. This marked biocidal activity offers a much wider range of effectiveness than solutions containing chlorine, cresylics, phenolics or quaternaries. Germicidal capacity is three to four times that of other germicides as tested on successive kills of seven common organisms.

WESCODYNE is the *first, "Tamed Iodine"® hospital germicide.* Nonstaining. Nonirritating. Nontoxic. Its amber color is a constant indicator of germicidal activity. When this color disappears, germicidal power has been exhausted. Send the coupon for full information, including recommended surgical, nursing and hospital procedures.

Programs and Specialties for
Preventive Maintenance and Protective Sanitation

WEST CHEMICAL PRODUCTS INC.

WEST DISINFECTING DIVISION

WEST CHEMICAL PRODUCTS INC., 42-16 West Street, Long Island City 1, N. Y.
Branches in principal cities • In Canada: 5621-23 Casgrain Ave., Montreal

☐ Please send recommended procedures and full information on Wescodyne.
☐ Please have a West representative telephone for an appointment.

Name .....

Position .....

Mail this coupon with your letterhead to Dept. 25

its chief sources of income. In the main, most boards of trustees of community hospitals now reflect, in their composition, the *former* sources of income. How many community hospitals in industrial areas today have union leaders on their boards along with businessmen?

Taking elective or administrative officials of local or state governments onto a board might bring partisan political involvements. Local conditions and the personalities of the officials will have to be weighed.

There are nevertheless compelling reasons for formal or informal interpenetration between hospital personnel and the personnel of government. Your percentage of income from local or local-state taxes may be 5 per cent or 10 per cent now; it is likely to be more in future. More important than this percentage are organizational issues which lie ahead. The relations of short-term hospitals to long-term care, to home care, to special hospitals, to nursing homes, to agencies of rehabilitation and prevention, must be dealt with on a planned basis, local and regional, if such major problems as the care of chronic illness and the medical care of the aged are to be solved. These problems will require a combination of private and governmental action, and they will call considerably upon public funds. It is of great importance to the voluntary nonprofit hospitals that such issues be worked out with government through the stages of discussion and policy-formation, and not just when they become issues of power.

CONFERENCES AND COMMITTEES

The principle of participation with labor and other important groups of insured persons can be expressed in additional ways, besides membership on hospital governing boards. Conferences are an illustration. These may be conference committees, meeting regularly or on call from any constituent. To be useful, they must come together sufficiently often to attain and then to maintain an area of mutual understanding.

In a considerable number of cities, there is a community services committee representing the labor unions as a body, designed to encourage participation by union members in all sorts of private and public enterprises of service. Often the local community services committee is in close relations with the community chest and the council of social agencies. The community services committee might often help hospitals in arranging conference groups with organized labor, or in selecting persons who, with the aid of the hospital administrator, would become informed so as to be effective board members.

Churches are important in every community. If your hospital is not an outgrowth of a particular denomination, but is a community institution, how many different church groups have members on your board of trustees?

There are other community elements to be considered. Some social, civic or church leaders may have significant value in diversifying a governing board and enriching its community powers. The executive officer of an important social agency is an example. Such a person may bring knowledge about the needs and problems of people whom you serve that no hospital insiders can provide.

Another big set of problems is already inside our doors, namely, the relations of physicians on hospital staffs to one another, to patients, and to the hospital organization. The issues are both organizational and financial. The present situation is unstable. More unified and more comprehensive service, and less confused financial arrangements in insurance plans, will be demanded by the American public. These demands will be led by the groups which will constitute the core of hospital financing.

PARTICIPANTS ARE FRIENDS

Participation is a two-way street. Those who walk on it for a while are likely to join in the middle of the road. Take people in as participants in one fashion or another, and they will come to understand something about the problems of a hospital. Furthermore, their personal, family and group interests are in favor of improved scope, unity, quality and economy of care. They are likely to support policies when convinced that these are the objectives. It is difficult to convince them of anything while they are on the outside, for then their approach is that of the critic, sharpened by the knowledge that their insurance plans or their taxes are major sources of your income. Participation means that the public and private groups which support you will deal with the hospital cooperatively instead of authoritatively.

Hospital administrators must be concerned with all sorts of things, from cleanliness in the corners of their closets to the planning of services 20 years ahead. There are those who will restrict their worries to what is on the desk today. There are others who will direct attention to the critical problems of tomorrow, and who will educate their staffs and their boards to do the same. Steps toward the hospital of 1975 should begin today.

NEWS DIGEST

Virginia Convention Speaker Urges Proper Use of Employes . . . Associated Hospital Service Study Reveals Home Nursing Care Can Reduce Costs . . . Catholic Association Conducts Session on "Patient-Centered" Administration . . . A.C.S. and Nurses to Meet

Speaker At Virginia Hospital Association Meeting Urges Proper Utilization of Employes

FORT MONROE, VA.—Proper utilization of all hospital personnel will go a long way toward relieving shortages, Dr. William T. Sanger, chancellor of the Medical College of Virginia, told delegates to the annual meeting of the Virginia Hospital Association recently.

For example, nurses should not do anything which can be done by someone else, Dr. Sanger said, and this principle can be applied in all departments of the hospital.

The shortages of nurses in Virginia is nearing 2000, he said. His suggestions to improve the situation also included: consider establishing a third state school of nursing; enlarge the present schools; recruit men to schools of nursing, since they do not leave the profession after marriage; encourage use of trained office personnel rather than nurses in doctors' offices; recruit older people to become practical nurses, and alert the public, through communications media, to the shortages.

Dr. Frank S. Groner, administrator of Baptist Memorial Hospital, Memphis, Tenn., discussed trustees and the medical staff from an administrator's point of view, enumerating the qualities that all three should exhibit, and the relationship that should exist among them.

The ideal trustee, said Dr. Groner, should possess strength of character; he should be scrupulously honest, generous with his time, familiar with the hospital, interested in people, and loyal to the administrator; he should be successful in his own field, thus enhancing his ability to make decisions and to offer constructive criticism; he should have planning ability and enthusiasm; he should support the medical staff; he should not attempt, in any manner, to function as an administrator or to assume his prerogatives; he should never seek personal gain for himself, his family, or his friends.

Responsibilities of the hospital plant engineer were outlined by Leland J. Mamer, director of buildings at St. Luke's Hospital, New York.

Virginia officers, seated left to right: Past President Raymond E. Hogan, President Harvie M. Clymer, President-Elect W. C. Bloxom. Standing: Roscoe B. Rhoads, left, and William R. Reid.

Many engineers, Mr. Mamer said, do poor work because of poor relations with the administrator; the administrator should take the initiative to make frequent visits to the department and comment on the work done.

The outstanding fault of the engineer is his lack of administrative understanding of what goes on in other departments, Mr. Mamer asserted. The administrator should point out these functions so the engineer will realize his responsibilities. The administrator also can encourage his engineer to attend hospital engineering institutes, to participate in community educational courses, to read hospital periodicals, and so on, Mr. Mamer said.

W. C. Bloxom, administrator of Johnston-Willis Hospital, Richmond, was named president-elect of the association. Harvie M. Clymer, administrator of Shenandoah County Memorial Hospital, Woodstock, was installed as president.

Other officers are: secretary, W. R. Reid, administrator of Jefferson Hospital, Roanoke, and treasurer, Roscoe B. Rhoads, business manager of Loudoun County Hospital, Leesburg. Both were reelected.

Elected to two-year terms as trustees were Raymond E. Hogan and Walter C. Walton.

Home Nursing Care Can Shorten Hospital Stay, Reduce Costs, Study Finds

NEW YORK.—A combination of hospital and home nursing services as part of the Blue Cross program could reduce the costs of illness and produce other benefits for patients and the community, the Associated Hospital Service of New York declared last month.

New York Blue Cross recently completed a five-year study to determine under what circumstances home nursing service would be advantageous to patients, the potential influence of visiting nurse services on the length of hospital stay, and the extent to which visiting nursing services might be provided by Blue Cross. New York hospitals and visiting nurse agencies cooperated in the study.

Early discharge from the hospital and subsequent home nursing care for 500 hospitalized Blue Cross subscribers saved 7948 days of hospital care, the study found. Hospital beds thus freed could have been used by more than 700 other patients for an average hospital stay of 11 days, it was reported.

The Blue Cross saved $73,432 by the shortened hospital stays, the report stated. A total of $25,425 was paid for visiting nurse service.

Savings to patients amounted to more than $79,000. Most of those who took part in the study already had received full Blue Cross benefits for 21 days of hospital care; after that period, they must pay 50 per cent of the hospital charges themselves to receive discount benefits. The combined program of hospital-home nursing care was most advantageous, therefore, for patients with prolonged or frequent periods of illness, the report said.

A survey of patients who participated in the study showed that the majority were pleased with the care they received under the plan, and about 85 per cent said they would willingly repeat the experience, the report stated. Doctors also expressed satisfaction with the results, according to the report.

Pittsburgh COLOR DYNAMICS®

creates cheerful surroundings that speed patients' recovery

There's no longer any reason why hospitals should be drab and cheerless. Not since Pittsburgh developed COLOR DYNAMICS. This modern system of painting has transformed many dull and dreary establishments into inviting and efficient institutions.

● **Medical men,** psychologists and hospital authorities have worked with Pittsburgh technicians and color experts to establish a basic system which utilizes color to achieve predetermined objectives.

● **By the use of COLOR DYNAMICS** patients' rooms are given color plans that contribute to the convalescence of patients. Color is used in operating rooms to relieve eye fatigue and nervous tension among surgeons. Color at nurses' stations promotes alertness and efficiency.

● **The comfort and morale** of resident staffs are enhanced by proper colors for the living quarters. By purposeful use of color, housekeeping and maintenance problems are simplified.

● **Why not use COLOR DYNAMICS** next time you paint? It can help to make your hospital a warmer, friendlier and more attractive place —at no greater cost than is required for normal maintenance painting.

We'll Make a Planned Color Study—FREE

● We'll be glad to send you a free copy of our book on COLOR DYNAMICS for hospitals. It explains the simple principles of this painting method and how to use them. Better still, we'll make a comprehensive color plan for your hospital, with detailed specifications, without cost or obligation. Call your nearest Pittsburgh Plate Glass Company branch and have one of our representatives see you at your convenience. Or send this coupon.

Send For This New Book—IT'S FREE!

Pittsburgh Plate Glass Co.,
Paint Div., Dept. MH-28
Pittsburgh 22, Pa.

☐ Please send me a FREE copy of "Color Dynamics."

☐ Please have your representative call for a Color Dynamics Survey of our properties without obligation on our part.

Name _____

Street _____

City _____ County _____ State _____

PITTSBURGH® PAINTS

SYMBOL OF SERVICE FOR SEVENTY-FIVE YEARS

75 ANNIVERSARY 1883 - 1958 PPG

PITTSBURGH PLATE GLASS COMPANY

IN CANADA: CANADIAN PITTSBURGH INDUSTRIES LIMITED

State Probe Asked in Hospital-Surgeon Feud

(*Continued From Page* 64)

Dr. Sullenberger. The hospital denies that any such recommendation was ever made and alleges instead that circumstances at the time of his departure were such that when Dr. Sullenberger returned in 1956, having spent two years in practice in Greenville, Miss., Brownwood, Tex., and Shreveport, La., the entire hospital staff recommended against his reappointment, which was effected only when he promised to "reform his ways" and signed an undated letter of resignation which the hospital held in reserve until October 29 last year, when the board of trustees of the hospital, at a special meeting, dismissed him.

Under hospital rules, Dr. Sullenberger continued to practice pending appeal to the board within ten days of the dismissal date. After two postponements, at his request, of scheduled appeal hearings, the board cracked down when Dr. Sullenberger appealed for a third postponement, and his privileges were withdrawn. The action was taken on recommendation and with full approval of the executive committee of the staff.

In 1952, Dr. Sullenberger had been dropped from the staff of St. Joseph Mercy, another Pontiac hospital. For a few days following his loss of privileges at Pontiac General, he operated at the Pontiac Osteopathic Hospital. Then, when his dispute with Pontiac General made headlines, he withdrew from Osteopathic, by agreement with the management. "We have nothing against Dr. Sullenberger," Harry Whitlow, director of Pontiac Osteopathic Hospital, said. "We both agreed that it would be in the best interests of all concerned if he stopped practicing here for the time being."

Denying all charges against him and claiming he was a victim of "hospital politics," Dr. Sullenberger told reporters he would perform surgery in a barn if he had to.

"It may come to that yet," said *Detroit Times* Columnist Harvey Taylor. "Dr. Sullenberger is running out of hospitals."

In citing instances of negligence, misconduct and improper behavior against Dr. Sullenberger, Flath's answer to the bill of complaint against him and the hospital acknowledged that he was not qualified personally to allege opinions in connection with professional care of patients but pointed out that "such conclusions are alleged on information obtained from expert sources, which information this defendant believes." Among the instances:

1. During an operation, Dr. Sullenberger refused to take the word of an assistant that a sponge was missing and failed to order an x-ray examination to verify the sponge count. The patient was returned to the hospital later with an internal abscess, a ruptured diaphragm and pneumonia. The patient died and autopsy indicated that death resulted from a sponge left in the abdomen during the operation.

2. An operation for "partial intestinal obstruction" was performed on an aged patient without adequate diagnosis and in spite of the fact that the x-ray report recommended further x-ray examinations, which were not made.

3. A critically ill patient was hospitalized for 13 days with a diagnosis of gastric intestinal bleeding but proper studies such as gastro-intestinal x-rays, clotting and liver function studies were not made, and the patient died. During his hospitalization he was visited only five times by Dr. Sullenberger.

4. Following a lung operation, Dr. Sullenberger visited a critically ill pa-

tient, who subsequently died, only six times in 23 days.

5. Following another operation for lung cancer, Dr. Sullenberger visited a patient only five times in 31 days.

6. During a gastrectomy, Dr. Sullenberger became sleepy and left the operating room, whereupon a resident surgeon had to be summoned from home to finish the operation. Moreover, it was charged, adequate preoperative studies on this patient had not been made and the operation was, in fact, unnecessary.

7. When a patient developed complications following bronchial surgery, Dr. Sullenberger refused to visit him and insisted that the complications were the fault of a resident who assisted him during the operation. In spite of requests by the resident and the patient's family, he refused to see the patient again.

8. A patient who died following an operation for cancer was visited only twice in nine days.

9. Dr. Sullenberger on one occasion scheduled operations for 7 and 8 p.m. but did not appear to operate until 10 p.m. and kept the operating room staff at work until 1:30 a.m., in the absence of any emergency.

10. A patient was admitted for tests and observation and visited the next day by Dr. Sullenberger, who did not appear again or communicate with the patient or his family for eight days, when the patient left the hospital without having received any care or attention from his physician.

11. Becoming infuriated at a doctor who was assisting him in an operation, Dr. Sullenberger was violent and abusive, used profane and obscene language and threatened the assistant with bodily damage, brandishing a scalpel.

12. During another operation he became violent and abusive toward a doctor and nurse assistant, used profane and obscene language, threatened to kick the doctor and became so enraged that surgery was interrupted.

Just prior to his dismissal from the staff, it was reported, Dr. Sullenberger's behavior toward interns and residents in the hospital was such that, at their request, all intern and resident operating room service and other routine house staff functions were denied him, with the approval of the executive committee of the medical staff and the board of trustees. The action was necessitated, according to a notification addressed to Dr. Sullenberger, by "long and continuing abuse of house staff members, culminating in their complete dissatisfaction in respect to professional relationships with you, and the related impact of this on their professional growth and learning experience." (*Cont. on Page* 132)

(*Continued From Page* 130)

Replying to the charges against him, Dr. Sullenberger acknowledged that he had become angry at assistants on occasion but insisted this was due to laxness and lack of cooperation and denied categorically that he had ever been guilty of unnecessary surgery or neglect of patients.

"They're all lies," he said of the Flath charges. Explaining the case of the missing sponge, he said:

"I received a correct sponge count from the circulating nurse in the operating room. There was no reason to suspect a missing sponge. The hospital pathologist did not do an autopsy. It was done by a first year resident, and, incidentally, the autopsy was secured and performed without my knowledge and without my being allowed to attend."

The procedures cited in every case were fully justified, Dr. Sullenberger declared, attributing the feeling against him to an "old guard, full of economics, jealousy and competition" at the hospital.

He denied falling asleep while operating but acknowledged that he had been tired on the occasion mentioned. "I had been operating close to 48 hours straight with no rest," he said.

Of the instances where inadequate preoperative study was charged, Dr. Sullenberger said he "followed his own judgment" when he disagreed with the findings of hospital examinations.

Dr. Sullenberger also denied abusing and threatening hospital personnel. "Sometimes I flare up and talk sharply with persons working with me," he said. "I guess I have the knack of alienating the feelings of people."

Pointing out that he had an unusually high proportion of critically ill patients, Dr. Sullenberger said he frequently performed "dangerous operations—operations that other doctors wouldn't touch or could not finish."

In reply to the charge that he failed to visit some patients often enough, he declared: "Nobody knows how many times a doctor visits his patients. If he depends on a nurse to write it on the chart, it isn't always accurate. You can be in and out of a room without a nurse seeing you."

Hospital attorneys said that both the Sullenberger complaint and the suit for unrestricted surgical privileges brought by other staff members were related to the Michigan Supreme Court's decision in the case of the Grand View Hospital of Gogebic County at Ironwood, Mich. The court held in that instance that trustees of the county hospital had no right to make rules or regulations affecting a physician's practice of medicine in the hospital in any way (see The Modern Hospital, June 1957, Vol. 88, No. 6, p. 93). Similarly in the present suits, the plaintiff physicians contend that "the sole authority for regulating the practice of physicians and surgeons in public hospitals is vested in the Michigan State Board of Registration in Medicine and that the local rules, constitution and by-laws have been improperly adopted, unreasonably enforced and should have no sanctity or effect."

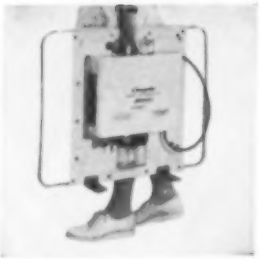
Midwest Group Will Meet in Kansas City, March 24-26

Omaha, Neb.—Preliminary plans for the 30th annual Midwest Hospital Association convention were reported in the January issue of the *Nebraska Hospital News*. Instead of the usual April date, the convention will be held March 24 to 26, officials said.

Skits will be used as the method of presenting four of the topics to be covered at the meeting, according to Carl Lamley of Topeka, Kan., the program chairman. One of these will be a "model board meeting" with representatives of all states in the Midwest association participating.

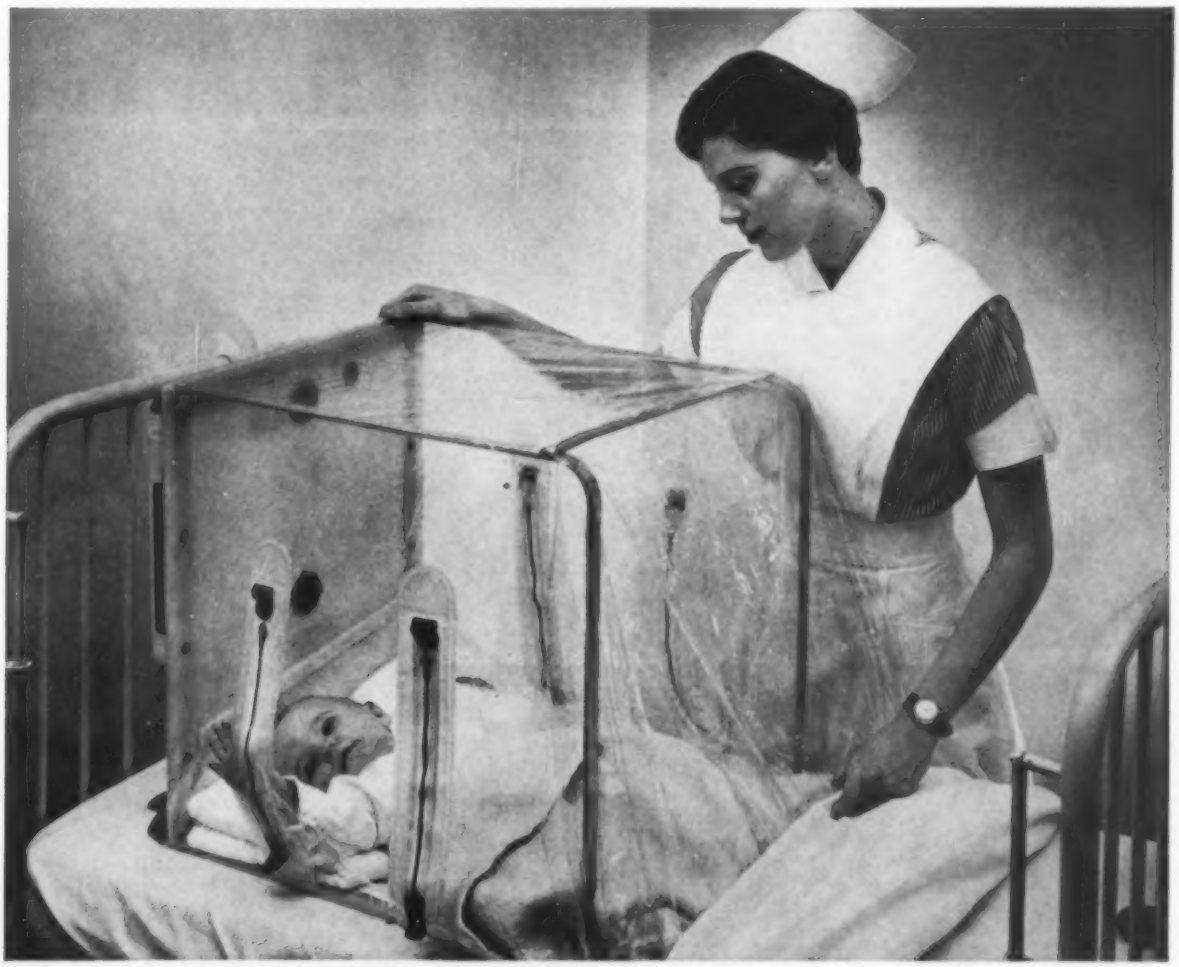
No wonder it's **standard equipment**

Over 83% of all hospitals in the U.S. accredited for residency training in pediatrics have purchased CROUPETTES. Moreover, one or more hospitals affiliated with each of the 75 approved U.S. Medical Schools have purchased CROUPETTES. First "cool vapor" croup tent, the CROUPETTE consistently excels all others in comfort, convenience and safety. The fresh, moisture-saturated air is effectively cooled and oxygenated by exclusive CROUPETTE forced circulation. Aerosol or oxygen therapy may be easily administered. With no moving parts, the CROUPETTE is as simple as it is safe and efficient.



Light, compact, portable.
Includes spare atomizer.

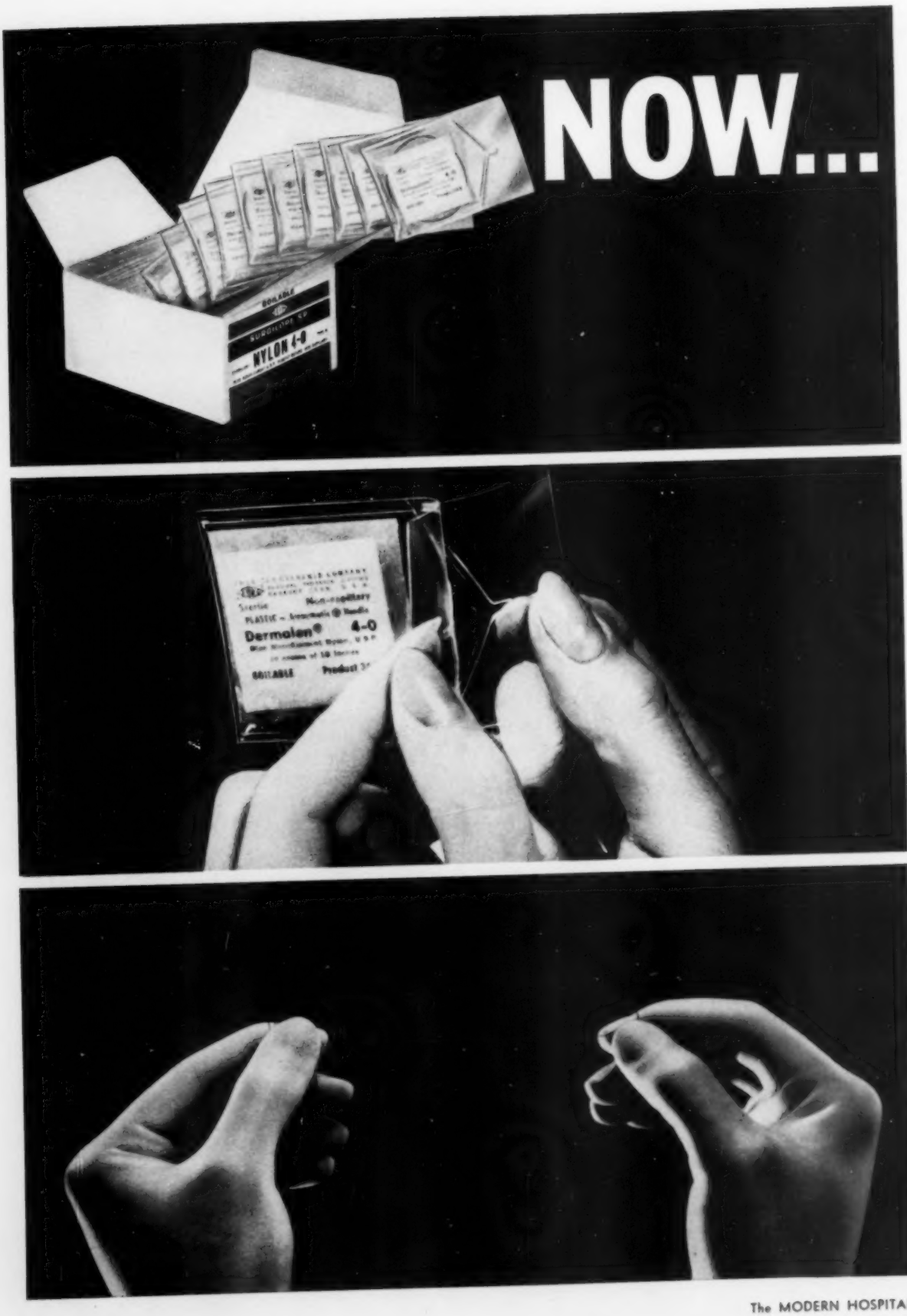
Visibility and accessibility are CROUPETTE features. Cooled, supersaturated, aerated vapor provides immediate relief and comfort.



The Croupette®

Cool-Vapor and Oxygen Tent By ***AIR-SHIELDS, INC.*** *Hatboro, Pa. OSborne 5-5200*

For information or orders, call us collect from any point in the U.S.A.


NOW...
NYLON 4-0
Dermalen®
4-0

Catholics Hold Session on "Patient-Centered" Hospital Administration

ST. LOUIS.—A conference on the "patient-centered" approach to hospital administration was conducted here last month by the Catholic Hospital Association and St. Mary's Hospital of Evansville, Ind.

The conference director was Howard E. Wooden, director of education for St. Mary's Hospital, who is also principal investigator of a research project in patient-centered hospital administration being conducted at the hospital under a grant from the U.S. Public Health Service.

Registration for the conference was limited to 50 administrators and supervisors in hospitals and related agencies, who heard lectures and took part in discussions of "therapeutic administration," the medical staff focused on the patient, the philosophic basis of hospital administration, relating facilities to medical staff and personnel functions, individualized patient care and management, hospital medical practice, and architectural concern for hospital patients as human beings.

Explaining the purpose of the conference, Mr. Wooden said: "Hospital administrative practice, preoccupied with the complexities and minutiae of the day, often tends to ignore the very goals for which the hospital as an institution came into being.

"To investigate some of the dilemmas faced in present-day hospital operation and to develop an understanding and appreciation of hospital administration, without losing sight of the patient as the ultimate end of all hospital activity, was the purpose of the research conference."

In the discussions, Mr. Wooden said, emphasis was placed on study and analysis of patients and their needs, evaluation of current administrative practice in terms of patient requirements, investigation of factors contributing to a "patient-centered" administration, and exploration of means of establishing the patient-centered approach.

"Researchers regard unresolved tensions between the patient and the hospital as expressions of the trauma which the individual experiences in a group setting," Mr. Wooden said, speaking of the research project at St. Mary's Hospital. "Specialization and fractionalization of services, the impact of policy on the individual, institutional policy *vs.* obligation to community, inconsistencies and inadequacies of leadership, insufficient farsighted planning in terms of actual needs and stated purpose, communication failures, and a host of others

Contemporary...colorful...and carefree —THEME lobby furniture by SIMMONS

This high-style *Theme* lobby furniture speaks in two voices. To your guests and visitors, it extends a friendly invitation, enhanced by the charm of glowing color and clean, contemporary lines. To you, the management, it tells of carefree, cost-saving maintenance—year after year of low upkeep costs.

Theme unit steel furniture by Simmons—a complete line of tables, chairs, sofas, cabinets and accessories—blends masterly design with sturdy construction that stands years of hard use. Tubular steel frames cannot loosen or sag. The upholstery—colorful, durable fabrics or tough Naugahyde. Special features protect your walls, floors and carpets from marring. Textolite tops provide positive protection against scratches or cigarette burns. No wonder *Theme* furniture makes charm a lasting investment!

Send now for illustrated literature on *Theme* and other furniture in the broad Simmons line.

CONTRACT FURNISHERS OF AMERICA

CFA TAKE 5 YEARS TO PAY

SIMMONS COMPANY

CONTRACT DEPARTMENT • Merchandise Mart, Chicago 54, Illinois
New York • Columbus • San Francisco • Atlanta • Dallas • Los Angeles

have brought on dilemmas, society-wide in scope, which have their respective counterparts in the hospital environment."

Among the lecturers at the conference were Temple Burling, director of the School of Industrial and Labor Relations at Cornell University and author of "The Give and Take in Hospitals"; Dr. Herman Finer of the department of political science, University of Chicago; Rev. John J. Flanagan, executive director of the Catholic Hospital Association; Gordon A. Friesen of Washington, D.C., hospital consultant; Dr. Martha O'Malley, director, Division of Hospital and Institutional Service, Indiana State Board of Health, and Richard J. Neutra of Los Angeles, architect and author of numerous books and magazine articles on the philosophy and social significance of architecture.

University to Sponsor 2d Congress for Nurses

BROOKLYN, N.Y. — The second annual Congress for Nurses, designed to keep graduate nurses informed of developments in education and in the care of the physically and emotionally ill, will be held at St. John's University here February 13.

Topics for the seven panels will be: the associate degree program, in-service education, research, the rôle of the professional in the economic order, care of the mentally ill, the challenge of extended illness, and exceptional children, including the emotionally disturbed and the mentally retarded.

25 Patients Evacuated as Fire Destroys Hospital

DUNCAN, OKLA.—Fire virtually destroyed the 27 bed Lindley Hospital here December 22, a loss estimated at $200,000. Nurses and kitchen personnel safely evacuated 25 patients, transferring most of them to other hospitals in the city. A few were released to their homes.

Witnesses said the fire was preceded by an explosion, apparently in a wall behind a basement refrigerator.

Donations Up 4 per Cent

NEW YORK.—American philanthropy totaled $6.7 billion in 1957, an increase of 4 per cent over contributions in 1956, the American Association of Fund-Raising Counsel has estimated. Gifts to health and welfare were estimated at $2.2 billion, with donations for hospital construction of approximately $202 million.

ANNOUNCING

10th Annual Short Course in

HOSPITAL HOUSEKEEPING

March 31 to May 23, 1958

Sponsored by the American Hospital Association in cooperation with Michigan State University, Kellogg Center for Continuing Education.

And again this year Huntington Laboratories is offering... TEN SCHOLARSHIPS

Anyone you select is eligible to compete...the Short Course in Hospital Housekeeping has but one objective—better patient care through better hospital housekeeping.

Anyone you select from your hospital may attend the course. Anyone from an AHA member hospital is eligible to compete for a Huntington Laboratories scholarship. The rules are simple. The person must be employed in an AHA hospital or promised employment upon completion of the course. Two letters of reference are necessary, plus a statement of 500 words or less from the person you select on "What benefits I expect to obtain from the Short Course in Hospital Housekeeping." Each scholarship is worth $300.00, which will cover the major portion of the room, board, tuition and book costs.

Application blanks are available by writing: **Huntington Laboratories Educational Fund, American Hospital Association, 18 East Division, Chicago 10, Illinois. Huntington Laboratories has no part in the selection of scholarship winners.**

HUNTINGTON LABORATORIES

INCORPORATED

Huntington, Indiana • Philadelphia 35, Pennsylvania • Toronto 2, Ontario

Michigan Employes to Win Cash for Successful Ideas

LANSING, MICH.—Hospital employes whose suggestions have saved money or improved service in their institutions will be eligible for $4000 in prizes in a contest announced last month by the Michigan Hospital Association and Michigan Blue Cross.

Purpose of the contest, said the association, is to help member hospitals exchange ideas that save money, improve operating methods, and bring better and more efficient service to patients and public. A grand award of $1000, four prizes of $500, and 10 awards of $100 will be presented to hospital employes who submit written reports of their successful ideas, it was reported.

No Surgery for GP's

ORADELL, N.J.—Family doctors who practice major surgery as well as medicine are "headed for extinction," Dr. Max Cheplove, head of the general practice section at Millard Fillmore Hospital, Buffalo, N.Y., said in a *Medical Economics* article. Rather than being trained as a part-time surgeon, the general practitioner should be learning as much general medicine as he possibly can, Dr. Cheplove stated.

Surgeon Says Five Advances Make Operations Safer for Patients Over 70 Years

ANN ARBOR, MICH.—Improved anesthesia; better methods of body fluid replacement, thus lessening physiological trauma; improved whole blood replacement; surgical technical advances, and improved preoperative and postoperative care in recent years have helped make surgery for persons over 70 safe, according to Dr. Frederick A. Coller, former chairman of the University of Michigan Medical School's department of surgery.

Dr. Coller, who spoke before the first meeting of the Michigan Society of Gerontology here last month, recently completed a study of more than 600 operations on persons over 70 years of age at University Hospital. Mortality rate was less than 6 per cent, he said.

Chances of recovering from surgery were found to be greatest among those between the ages of 70 and 79, he said. However, 84 per cent of those over 90 survived the operation and left the hospital in good condition, he reported.

Chief causes of postoperative deaths were preexisting diseases, such as hardening of the arteries involving primarily the brain, heart and kidney, and cancer, Dr. Coller said.

College of Surgeons Plans Joint Meetings With Nurses

CHICAGO. — A joint program for nurses and surgeons will feature the four-day sectional meeting of the American College of Surgeons, March 3 to 6 in New York, it was announced at the college headquarters here last month.

Subjects scheduled to be included are: nursing the patient who has cardiac surgery; the rôle of the nurse in the outpatient department; care of the patient during diagnostic procedures; the operating room nurse and the patient; postoperative nursing care; the rôle of the public health nurse following surgery; psychological impact of cancer and its therapy, and psychological resources for the surgical patient, a panel discussion, A.C.S. officials stated.

Lutheran Hospitals Merge

PUYALLUP, WASH. — Lutheran Hospital and Good Samaritan Hospital of Puyallup, both operated by the Lutheran Welfare Society of Tacoma, Wash., have been consolidated under the name of Good Samaritan Hospital. The former Lutheran Hospital, built in 1952 as a chronic-convalescent hospital, is being remodeled into an acute general hospital.

COMING EVENTS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, First Congress, Congress Hotel, Chicago, Feb. 9-11.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Institutes: Minnesota, University of Minnesota, Feb. 17-21; 8th New York, New York, June 23-27; 8th Western, Palo Alto, Calif., June 23-27; 26th Chicago, University of Chicago, Sept. 2-12; 9th Chicago Advanced, University of Chicago, Sept. 8-12.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Members Conferences: Regions 17, 18, Montreal, Que., April 14-18; Region 11, Kansas City, Mo., Oct. 20-24; Region 10, Minneapolis, Oct. 27-31; Region 1, Boston, Nov. 10-14; Region 8, East Lansing, Mich., Nov. 17-21.

AMERICAN COLLEGE OF SURGEONS, Joint Nurses-Surgeons Meeting, Commodore Hotel, New York, March 3-6.

AMERICAN HOSPITAL ASSOCIATION, convention, Palmer House, International Amphitheater, Chicago, Aug. 18-21.

AMERICAN HOSPITAL ASSOCIATION, Midyear Conference of Presidents and Secretaries of State and Regional Hospital Associations, Palmer House, Chicago, Feb. 7, 8.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Morrison Hotel, Chicago, Feb. 11-14.

ASSOCIATION OF OPERATING ROOM NURSES, Bellevue-Stratford Hotel, Philadelphia, Feb. 10-12.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, April 21-24.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 24, 25.

CATHOLIC HOSPITAL ASSOCIATION, Atlantic City, N.J., June 21-26.

COMITÉ DES HÔPITAUX DU QUEBEC, Montreal Show Mart, Montreal, Que., June 25-27.

GEORGIA HOSPITAL ASSOCIATION, Ralston Hotel, Columbus, Feb. 20, 21.

INDIANA HOSPITAL ASSOCIATION, Indiana Student Union Building, Indianapolis, Oct. 8, 9.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 13, 14.

KENTUCKY HOSPITAL ASSOCIATION, Sheraton-Seelbach Hotel, Louisville, April 15-17.

LOUISIANA HOSPITAL ASSOCIATION, Bellemont Motor Hotel, Baton Rouge, March 20-22.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 3-5.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, May 15.

MICHIGAN HOSPITAL ASSOCIATION, Grand Hotel, Mackinac Island, June 17, 18.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 21-23.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., March 24-26.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Hotel del Coronado, Coronado, Calif., April 14-18.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Morrison Hotel, Chicago, Feb. 11-13.

NATIONAL GERIATRICS SOCIETY, 5th annual convention and exposition, Henry Hudson Hotel, New York, May 13-15.

NEBRASKA HOSPITAL ASSOCIATION, Omaha, Oct. 23, 24.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 24-26.

NEW MEXICO HOSPITAL ASSOCIATION, Hilton Hotel, Albuquerque, March 10-12.

OHIO HOSPITAL ASSOCIATION, Netherland-Hilton Hotel, Cincinnati, March 10-13.

OKLAHOMA HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 6, 7.

SOUTHEASTERN HOSPITAL CONFERENCE, Hotel Fontainebleau, Miami Beach, Fla., May 14-16.

TENNESSSEE HOSPITAL ASSOCIATION, Hotel Patton, Chattanooga, March 13-15.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, May 5-8.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 28-30.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis Auditorium and Leamington Hotel, Minneapolis, May 14-16.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 14-16.

WASHINGTON STATE HOSPITAL ASSOCIATION, Winthrop Hotel, Tacoma, Oct. 15, 16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Daniel Boone Hotel, Charleston, Oct. 15-18.

Child Study Center to Open

LOS ANGELES.—A Child Study Center at Mount Sinai Hospital here is scheduled to be completed in March, it was announced last month. The center will be used for psychiatric research and outpatient clinical work with children in a nursery school setting, Walter J. Mezger, administrator of Mount Sinai, said.

Protestant Associations Announce Speakers

CHICAGO. — The American Protestant Hospital Association will convene for its 37th annual meeting in Chicago on February 14 following three days of meetings scheduled by its 12 component Protestant denominational groups.

The A.P.H.A. and the denominational meetings will be held in the Morrison Hotel here.

The denominational groups include the Commission on Benevolent Institutions of the Evangelical and Reformed Church; Southern Baptist Association of Hospital Chaplains; National Association of Methodist Hospitals and Homes; Association of American Baptist Homes and Hospitals; Southwide Baptist Hospital Association; the Salvation Army; National Presbyterian Health and Welfare Association; Assembly of Episcopal Hospitals and Chaplains; Association of Mennonite Hospitals and Home; Chaplains' Association of the American Protestant Hospital Association, and the Lutheran Hospital Association of America.

"Meeting Nursing Needs in Protestant Hospitals" will be the topic at the Friday morning session of the A.P.H.A. Speakers will include Dr. Frank R. Bradley, director, Barnes Hospital, St. Louis, presenting the administrator's solution; Edith Payne, director of nursing service and nursing education, Presbyterian-St. Luke's Hospital, Chicago, giving the nurse administrator's solution, and David Kinzer, executive director, Illinois Hospital Association, presenting the state association solution.

Student Personnel Services in an Accredited School of Nursing will be the topic of a series of group meetings to be held by the National Association of Methodist Hospitals and Homes on February 12.

New Jersey Plans Hit Record Benefits in 1957

NEWARK, N.J. — New Jersey Blue Cross and Blue Shield officials estimate that benefits paid during the 12 months ending Sept. 1, 1957, were the highest in the history of the organization—a total of $67 million.

Blue Cross, with a record high of more than 2,060,000 individuals enrolled, paid an estimated $45¾ million on approximately 310,000 claims during the year, officials of the organization stated.

Blue Shield, now helping more than 1,670,000 individuals pay medical-surgical bills, expended an estimated $21⅛ million on some 240,000 cases for which claims were filed.

Look first at the floors in your hospital—are they dark . . . cheerless . . . depressing? Do they create a favorable impression on visitors, patients and staff — or do they have the opposite effect?

Solution:

Vina-Lux® FLOORS

WITH

Micromatic Veining

Vina-Lux floors can solve your problem . . . with colors that are light, bright, spirit lifting! Vina-Lux colors show dirt less — are quick and easy to clean. Write for descriptive folder and color chart.

Remember . . . Vina-Lux costs less to own per foot per year!

AZROCK FLOOR PRODUCTS DIVISION

UVALDE ROCK ASPHALT CO. | 511 FROST BANK BLDG. • SAN ANTONIO, TEXAS

MAKERS OF VINA-LUX • AZROCK • AZPHLEX • DURACO

Johns Hopkins Expansion to Include $11 Million Pediatric Medical Center

BALTIMORE. — More than 21 per cent of a $76.4 million Johns Hopkins Development Project announced recently by the university is earmarked for hospital facilities.

Including expansion planned for the school of medicine and the school of hygiene, 48 per cent of the fund will be used for health projects.

The largest single new building contemplated under the program is a children's medical center which will cost $11 million.

The program was announced by Dr. Charles S. Garland, who is chairman of the Johns Hopkins Fund.

Citing the difficulties imposed by the fact that present pediatric facilities in the city of Baltimore are scattered, Dr. Garland said that the plan for the children's medical center was developed cooperatively by the university, the Garrett Fund for the Surgical Treatment of Children, the Harriet Lane Home, and the Eudowood Sanitorium. The latter three foundations have already pledged approximately $6 million toward the new building.

The proposed center will be housed in a new 10 story building to be erected as an integral part of the Johns Hopkins Hospital. It will provide modern facilities for the care of between 200 and 300 patients, a large outpatient clinic section, and research laboratories.

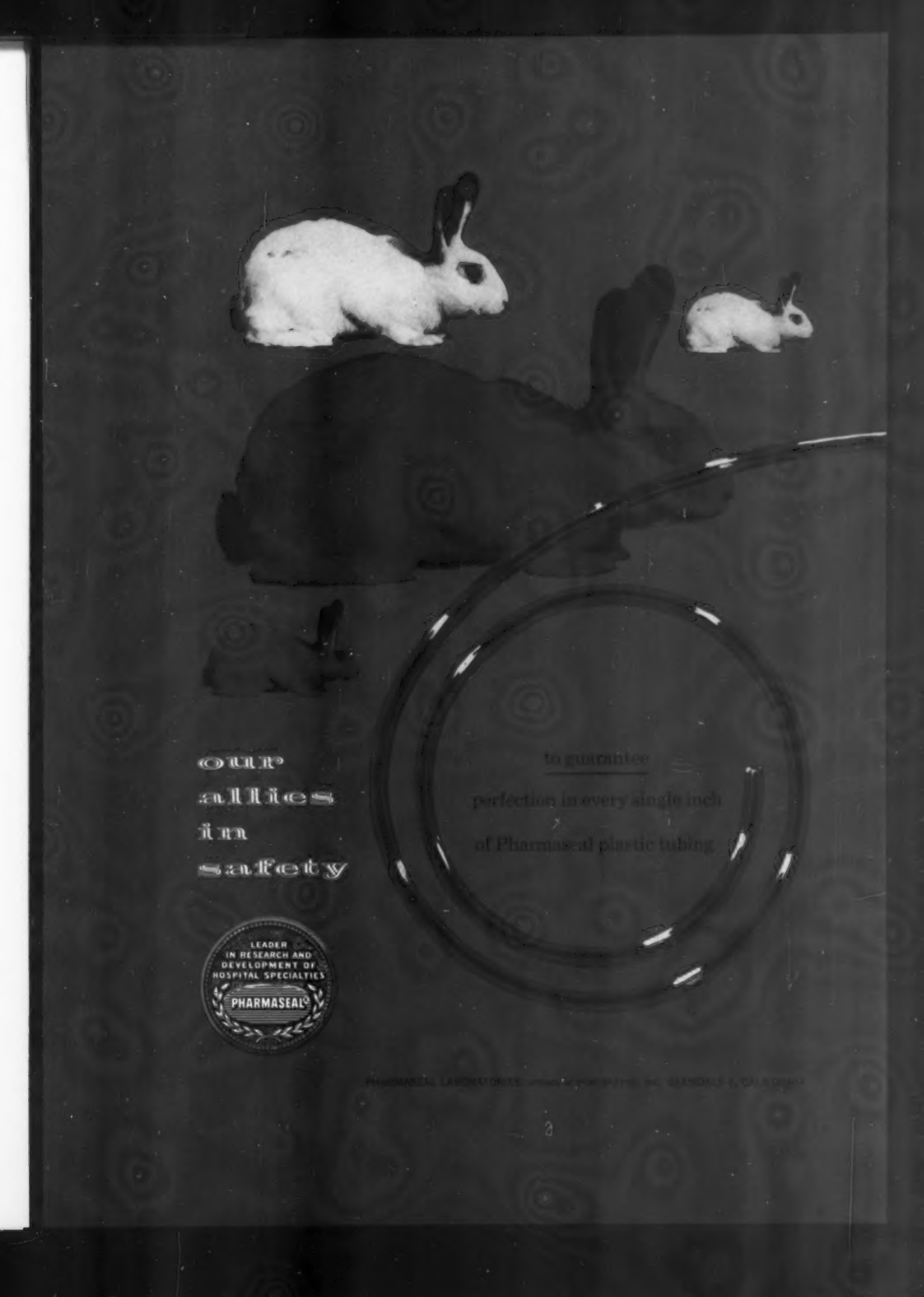
According to university authorities, the new center will not only provide superior medical care for sick children but will also house outstanding research and training units for physicians and scientists interested in the special problems of childhood. It will allow all of the children's activities in the Johns Hopkins Hospital to be consolidated in one unit, with a single combined team of medical, nursing and scientific personnel. The center will also provide facilities for the care of children formerly treated in certain special hospitals and will make possible a stronger affiliation with those special units in the community which are not joined physically with the center. The resulting consolidation will lead to a better integration of patient and staff, and will in the long run not only improve the medical care of children but will also strengthen the programs in teaching and research. Finally, by bringing specialized scientists, physicians and staff under one roof, the new center will provide a unique and badly needed diagnostic center for the handicapped child, officials stated.

Other improvements contemplated for the hospital in its $15.5 million program include: new facilities for psychiatric service, $2 million; a new women's clinic, $3 million; an addition to the nurses' residence, $2 million, and additional outpatient facilities, $2.5 million.

Operating funds valued at $12.5 million, a new biophysics building for $1 million, and modernization projects totaling $630,000 are contemplated for the school of medicine, while the school of hygiene is scheduled to receive $5.2 million for operating funds, $1 million for rehabilitation of existing plant, and $1 million for new construction.

School Starts New Service

ANN ARBOR, MICH.—A bureau of hospital administration has been established by the University of Michigan within its school of business administration, it was announced recently. The bureau will provide community services and conduct research in hospital administration, supplementing the school's program in hospital administration. Prof. Walter J. McNerney, director of the hospital administration program, will be director of the bureau.


our
allies
in
safety
to guarantee
perfection in every single inch
of Pharmaseal plastic tubing
LEADER
IN RESEARCH AND
DEVELOPMENT OF
HOSPITAL SPECIALTIES
PHARMASEAL

these tests

BIOLOGICAL TESTS

- Acute toxicity
- Chronic toxicity
- Antigenicity
- Pyrogen
- Ocular instillation
- Tissue irritation
- Tissue tolerance (gross and histological)
- Vasomotor
- Bacteriological

are performed on

PHYSICAL TESTS

- Inertness to acidic and basic solutions
- Hardness
- Flexibility
- Elasticity
- Strength
- Dimensional accuracy and stability
- Receiving inspection
- Continuous inspection
- Functional tests

Pharmaseal plastic tubes

Who else but PHARMASEAL gives you this assurance?

The finest line of plastic tubes...

priced for expendability

PHARMASEAL LABORATORIES

affiliate of DON BAXTER, INC.

GLENDALE 1, CALIFORNIA

PHARMASEAL®

Montefiore Hospital Unit Speeds Up X-Ray Service

NEW YORK.—Two new machines designed to speed x-ray service up to 90 per cent have been installed at Montefiore Hospital here, it was announced last month.

A new processing device for developing x-rays will do in six minutes a process that formerly required one to two hours, according to Dr. Martin Cherkasky, hospital director. The $30,000 unit is said to eliminate film hangers and external chemical baths and replenish processing solutions continuously, requiring changes only once every six to 12 months.

The other device is a number coded machine punch system that will provide the hospital with a speedier, more accurate breakdown of patients passing through the x-ray department and is expected to simplify the problems of doctors who seek to locate cases of specific types for research or reference.

United Hospital Fund Names New President

NEW YORK. — The directors of the United Hospital Fund of New York have elected Percy J. Ebbott president of the group in a special election to fill the vacancy caused by the death of C. Parker McComas.

Mr. Ebbott is the former president and director of the Chase National Bank and is now chairman of the trust advisory board of the Chase Manhattan Bank of New York.

He assumes the presidency of the fund at a time when it has recently expanded its activities by taking into its organization the 86 year old New York City Hospital Visiting Committee, which has more than 100 active volunteers who visit all municipal hospitals to report regularly on problems and conditions.

Cedars of Lebanon Starts $11 Million Expansion Plan

LOS ANGELES. — The second phase of a $11 million expansion program at the Cedars of Lebanon Medical Center will get under way soon with the construction of a $1 million rehabilitation center at the hospital.

The 20,000 square foot structure, which will adjoin the present maternity-pediatrics pavilion, will enable Cedars to triple its patient capacity.

Scheduled as a two-story structure with another floor below ground level, the new rehabilitation center will be constructed to allow the addition of two more stories. It is designed by Faxon, Gruys and Saylor.

Electronic Sterilization Of Sutures Is Introduced

SOMERVILLE, N.J. — An electron beam sterilization process for catgut sutures was introduced to the hospital industry in conjunction with the opening last month of the new Somerville, N.J., plant of Ethicon, Inc.

The atomic sterilization features the first commercial use of a microwave linear accelerator for sterilization of a medical product. The accelerator was developed in cooperation with High Voltage Engineering Corp.

The process works as follows:

Completely sealed tubes (under the former heat sterilization method the tubes were not sealed until after sterilization) containing sutures are passed along a moving belt into a room lined with 7½ feet of concrete and under a vacuum tube about 8 feet long.

The electrons are set in motion by a 50,000 volt filament at the top of the tube. A radar wave is flowed through the tube and brings the electrons to the bottom of the tube, employing the momentum-gaining principle that can be likened to the speed gained by a surfboard as it rides toward the beach so that at the bottom of the tube the electrons are traveling at almost the speed of light.

There are electromagnets at each side of the bottom of the tube which alternate the scan of the electron beam so that there is complete coverage of all the suture containers over a period of several seconds.

The sterilization is accomplished as the electrons destroy all microorganisms in or on the catgut suture by altering the molecular structure of the bacteria without disturbing the structure of the suture itself.

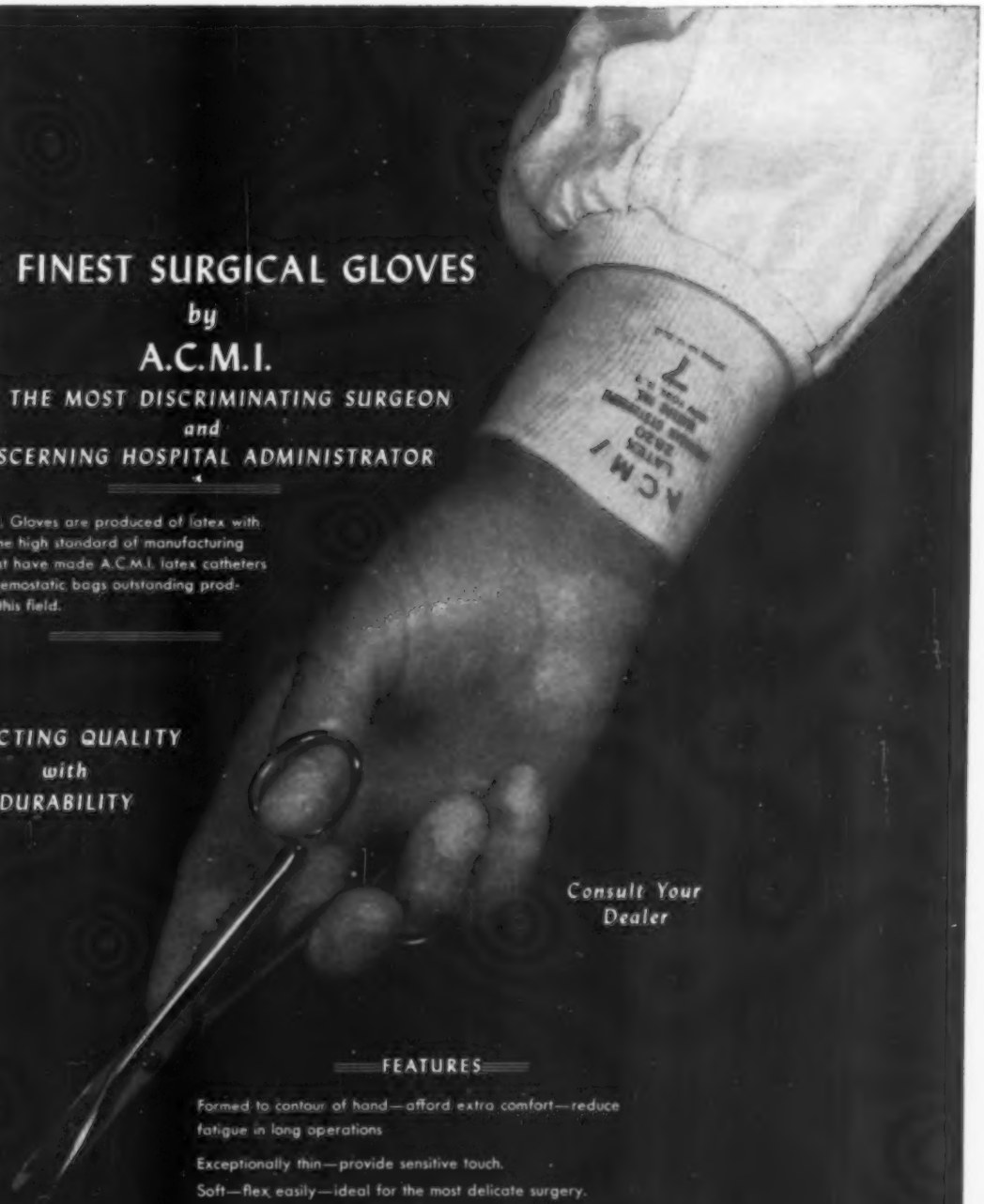
The electron—the negative electrical charge of the atom—is used in the sterilization process because it does not produce any residual radiation, nor is there any formation of radioactive by-products in the material being sterilized.

Administrators Name Head

BOSTON. — The recently organized American Academy of Medical Administrators has elected Hugh C. McEwan, chief of the medical administration division of the Veterans Administration hospital in Brockton, Mass., as its first president.

Hospital to Sell Home

GREENWICH, CONN.—St. Luke's Hospital in New York City has made plans to sell its 206 acre convalescent center here and transfer its convalescent and research activities to New York, it was announced recently.



THE FINEST SURGICAL GLOVES

by

A.C.M.I.

FOR THE MOST DISCRIMINATING SURGEON
and
DISCERNING HOSPITAL ADMINISTRATOR

A.C.M.I. Gloves are produced of latex with the same high standard of manufacturing skill that have made A.C.M.I. latex catheters and haemostatic bags outstanding products in this field.

EXACTING QUALITY
with
DURABILITY

Consult Your Dealer

FEATURES

Formed to contour of hand—afford extra comfort—reduce fatigue in long operations

Exceptionally thin—provide sensitive touch.

Soft—flex easily—ideal for the most delicate surgery.

Durable—safe for patient and surgeon.

Withstand repeated sterilization.

Retain their shape—are tough and highly tear resistant.

Economical in price combined with highest quality.

Cat. No. 2820—White
2830—Brown

ESTABLISHED IN 1910 BY REINHOLD WAPPLER

FREDERICK J. WALLACE, President

American Cystoscope Makers, Inc.

5 PELHAM PARKWAY PELHAM MANOR, N. Y.

ABOUT PEOPLE

(*Continued From Page* 81)

Leon Winkler has been appointed administrator of Homes County Hospital, Bonifay, Fla. Mr. Winkler, who served his administrative residency at Hamilton Memorial Hospital, Dalton, Ga., is a graduate of Georgia State College of Business Administration.

Dr. Russell L. Hiatt, manager of the Veterans Administration hospital at Fort Wayne, Ind., has been transferred as manager of the V.A. hospital at Louisville, Ky., succeeding **Dr. Harvey C. Hardegree,** who has retired. **Dr. Michael H. Travers,** director of professional services at the V.A. center in Kecoughtan, Va., will become manager and director of professional services at the Fort Wayne hospital.

Henry A. Thornton has resigned as administrator of Piedmont Hospital, Piedmont, Ala. His future plans have not been announced.

Dr. Prince P. Barker, director of professional services at the Veterans Administration hospital in Tuskegee, Ala., has been appointed manager of the hospital, succeeding **Dr. Toussaint T. Tildon,** who has retired. The Veterans Administration also announced that **Dr. Sam Beanstock,** director of professional services at the V.A. hospital in Lebanon, Pa., will be transferred as manager of the V.A. hospital in Chillicothe, Ohio. He will succeed **Dr. Harry H. Botts,** who has retired.

Dr. Otto Schaefer, director of professional services at the Veterans Administration hospital in Roseburg, Ore., has been appointed manager of the V.A. hospital in Danville, Ill. He succeeds **Dr. Oreon K. Timm,** who is now director of the area medical office in St. Paul, Minn.

Department Heads

Helen Watters, R.N., has been appointed director of nursing services for the University of Washington's teaching hospital, scheduled to open in early 1959. Miss Watters previously was assistant administrative nursing supervisor at University of Minnesota Hospital, Minneapolis, for five years. At the same time it was announced that **Harriet R. Kossove** has been named director of the dietary department, with responsibility for the health sciences building at the University of Washington. She has been a hospital dietitian with the Public Health Service and also has served in hospitals in Miami Beach, Fla., and Chicago.

Kathryn S. Harris, R.N., has been appointed operating room supervisor at Berea College Hospital, Inc., Berea, Ky. Mrs. Harris is a graduate of Johns Hopkins Hospital's postgraduate course in operating room technic and has recently been employed at the Good Samaritan Hospital, West Palm Beach, Fla. She served in the army nurse corps during World War II and was discharged with the rank of major.

Maurice A. Garland

Maurice A. Garland has been appointed director of public relations for Paradise Valley Sanitarium and Hospital, National City, Calif. Mr. Garland recently was associated with the National Multiple Sclerosis Society as central states regional representative in Chicago.

Robert Bruce has resigned as business manager of Lee Memorial Hospital, Fort Myers, Fla., to become administrator of Charlotte Hospital, Punta Gorda, Fla. **Charles Zolers** has been named to succeed Mr. Bruce as business manager.

H. M. Baldwin, business manager of Walker Memorial Sanitarium and

Which ice is best for you?

Carrier gives you your choice—with Certified Capacity

With a Carrier Automatic Icemaker, you get the ice that's right for *you*, because Carrier has the most complete line in existence . . . 15 Carrier models for cubes, crushed, flakes or chips.

With a Carrier Icemaker, you get guaranteed ice production based on conditions of air and water temperature found in *your* locality . . . Certified Capacity *in writing*, a Carrier exclusive!

Isn't it time you looked into the advantages of a Carrier Icemaker? Your Carrier dealer can show you, with facts and figures, how you can save as much as 80% on ice bills . . . get the ice you want . . . and get it in *certified* amounts instead of "up to" so many pounds per day.

Your Carrier dealer is listed in your Yellow Pages under "Ice Making Equipment." Or write Carrier Corporation, 323 South Geddes St., Syracuse, New York.

Carrier

air conditioning • refrigeration

Hospital, Avon Park, Fla., for 10 years, has accepted a similar position at the Bangkok Sanitarium and Hospital, Bangkok, Thailand.

Anna Sabara, R.N., recently was named associate director of nursing education at Research Hospital, Kansas City, Mo. Miss Sabara is a graduate of Mount Sinai Hospital's school of nursing, Chicago, and received a master's degree from the University of Chicago. Previously, she had been supervisor and clinical instructor of the obstetrical department and assistant supervisor of the operating room at Mount Sinai Hospital, and an assistant night supervisor at the University of Chicago clinics.

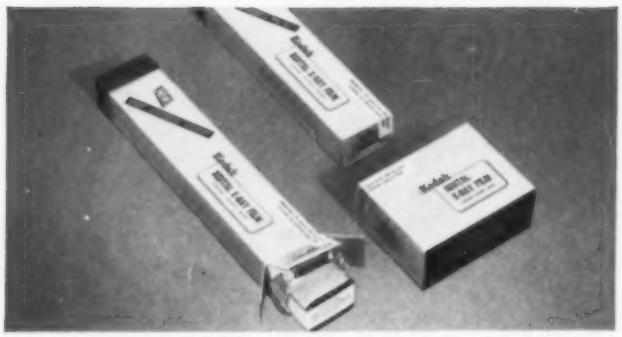
Kenneth Stuart has been named director of nursing education at Long Island College Hospital School of Nursing; he is the first male nurse to become an executive at the school. Mr. Stuart received a master's degree from Harvard University.

Miscellaneous

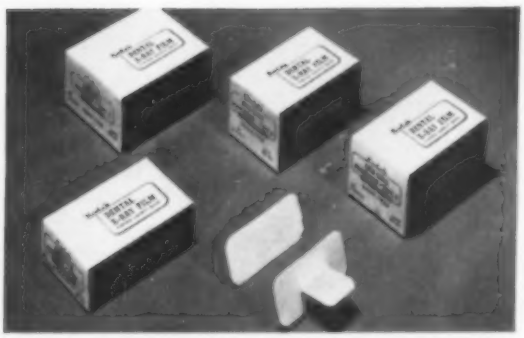
Richard L. Johnson, secretary of the American Hospital Association's Council on Administrative Practice, has been appointed director of the association's new hospital counseling program. The five-year program, designed to provide on-the-scene administrative counseling to hospitals requesting it, was made possible by an $825,000 Ford Foundation grant and announced at the association's annual meeting in October. Associate director of the program will be **William T. Middlebrook,** who has been assistant administrator of Hibbing General Hospital, Hibbing, Minn., since 1956. Previously, he was assistant superintendent of University of Missouri Hospital; Mr. Middlebrook is a graduate of the hospital administration program of the University of Minnesota. **Robert S. Borczon** has been appointed assistant director of the counseling program; currently he is a staff representative of the Council on Administrative Practice.

Robert G. Hoffmann

Robert G. Hoffmann has been appointed statistician at J. Hillis Miller Health Center and assistant research professor at the University of Florida's statistical laboratory, Gainesville. Mr. Hoffmann formerly was associated with the Commission on Professional and Hospital Activities, Inc., from 1953 to 1957. He received his bachelor's degree from Stanford University and



1. **September, 1955:** Announcement was made that Kodak Periapical Ultra-Speed Dental X-ray Film had been made *3 times faster* than the previous film.



2. **September, 1956:** *The doubling of the speed* of Kodak Radia-Tized Films—Periapical and Bite-Wing—was announced.

FASTER . . . During the past 2 years Kodak Medical and Dental X-ray Films have been greatly increased in speed

3. **July, 1957:** Kodak Royal Blue Medical X-ray Film—*the fastest medical x-ray film available*—was introduced. (Experience shows that exposures can generally be cut in half—with development for 5 minutes at 68 F in Kodak Liquid X-ray Developer and Replenisher or Kodak Rapid X-ray Developer.)

4. **January, 1958:** New Kodak No-Screen Medical X-ray Film now available. *Increases speed 50%.*

5. **February, 1958:** Kodak Photoflure Medical X-ray Film, Green Sensitive, 35mm and 70mm rolls, *now twice as fast.*

See illustrated price list "Kodak X-ray Materials" for full details. Your dealer carries a full stock of Kodak x-ray products. Phone or write him about your needs. You can be sure of prompt service, as well as technical help.

Kodak
TRADE MARK

EASTMAN KODAK COMPANY, *Medical Division*, Rochester 4, N.Y.

master's and doctor's degrees from the University of Michigan.

Kenneth C. Cross has assumed the position of assistant secretary in charge of public relations for the Canadian Medical Association. Mr. Cross previously was public relations director of the Ontario Hospital Association for more than 10 years.

Dr. Charles L. Wilbar, deputy secretary of the Pennsylvania Department of Health since 1953, has been appointed secretary of health, succeeding **Dr. Berwyn Mattison.** Dr. Mattison's appointment as executive director of the American Public Health Association was reported in the January issue of The Modern Hospital.

Louis G. Polk has joined the accident prevention unit of the division of special health services for the U.S. Public Health Service. Mr. Polk is a graduate of Georgia State College of Business Administration.

Dr. Charles G. Hayden has been appointed acting executive director of Blue Cross in Massachusetts, succeeding the late **Roger W. Hardy.** Dr. Hayden also serves as executive director of Blue Shield in that state.

Deaths

Thomas E. Leet, administrator of Chester General Hospital, Chester, Pa., died recently. He had served the hospital for 10 years.

THE BOOK SHELF

Hospital Accreditation References, *American Hospital Association, Chicago. Pp.* 136. *Price,* $3.25.

This book is a compilation of official requirements, recommendations and interpretations of the Joint Commission on Accreditation of Hospitals as they have appeared in print or in unpublished correspondence.

Subjects are arranged in the same pattern as those in the "Standards for Hospital Accreditation" and an index also is included. The book will be revised as necessary, the association has announced.

Material is separated in each chapter as to its origin, *i.e.* the Standards; the Bulletin of the Joint Commission; survey report forms; model medical staff by-laws, rules and regulations; by-laws of the Joint Commission, and questions from correspondence.

Chapter I contains the by-laws of the Joint Commission. This is followed by chapters on those areas deemed essential for accreditation.

including physical plant, and governing board. Dietary, medical records, pharmacy or drug room, laboratories, radiology and medical library departments are then discussed.

The medical social service department and emergency service each comprise a chapter.

The medical staff is divided into four chapters: responsibilities, membership, organization and departmentalization.

Departments of medicine, obstetrics, surgery, anesthesia, general practice, rehabilitation, and the outpatient department are covered.

Chapters on dentistry and nursing departments conclude the book.

COST FINDING FOR HOSPITALS. *Committee on Accounting and Business Practices, American Hospital Association. Chicago,* 1957. *Pp.* 136.

This manual will be welcomed by everyone who is interested in the subject of the cost of hospital services. Its purpose and scope, as explained in the introduction, are worth noting, especially the following statement: "Closer inspection of certain functions may result in the determination of a way to effect economies, the decision to revise the rate structure, or the determination of more adequate basis of cost for negotiation purposes."

Chapter 1 on the nature and use of cost data gives a clear picture of just what cost data are, and how they can be used purposefully by administrators. Of particular significance in this chapter is the discussion of unit cost figures because they often give clearer representations of variations in costs than do total figures.

General cost finding procedures in hospitals are fully discussed in Chapter 2. In this chapter, five purposes for which costs may be accumulated by general cost finding procedures are given. I believe that a sixth, and equally important purpose, should be added to this list. This sixth purpose is "a comparison of budgetary unit costs with actual costs to provide better administrative control."

The discussion of the three methods of cost finding and the clear-cut illustrations of procedure are excellent.

In discussing this new manual with several well informed hospital administrators, I found that some people feel that the new manual is unnecessarily complicated and difficult to follow. Any manual of this scope must be somewhat technical in nature and this one was not developed for novices in accounting. It is intended to guide those who understand accounting principles in setting up cost procedures in their hospital. (*Cont. on p.* 158)

New QUIET for Hospital Quiet-Zone

When quiet prevails in a hospital, everyone benefits. In many of the country's hospitals, such as the Indianapolis Community Hospital, sound-absorbing ceilings of Acousti-Celotex Tile bring *quiet comfort* to all areas . . . speeding patient convalescence, raising personnel efficiency and morale. Acousti-Celotex Sound Conditioning checks noise effectively in corridors, lobbies, kitchens, utility rooms, wards, nurseries, operating and delivery rooms. **Mail Coupon Today** for a *free analysis* of the noise problem in your hospital, plus free booklet.

Delivery room of the Indianapolis Community Hospital, Indianapolis, Indiana, showing ceiling of Acousti-Celotex Random* Pattern Perforated Mineral Fiber Sound Conditioning Tile. Architect: Daggett, Naegele & Daggett. Acousti-Celotex Contractor: Hugh J. Baker & Co.

*PAT. NO. D-168,765

ACOUSTI-CELOTEX
REGISTERED U. S. PAT. OFF.
Sound Conditioning
TRADE MARK

Products to Meet Every Sound Conditioning Problem . . . Every Building Code—The Celotex Corporation, 120 S. LaSalle St., Chicago 3, Illinois • **In Canada:** Dominion Sound Equipments, Ltd., Montreal, Quebec

MAIL NOW!

The Celotex Corporation, Dept. G-28
120 South La Salle Street, Chicago 3, Illinois

Without cost or obligation, please send me the Acousti-Celotex Sound Conditioning Survey Chart, and your booklet, "The Quiet Hospital."

Name _____ **Title** _____

Hospital _____

Address _____

City _____ **Zone** _____ **State** _____

In Chapter 4, covering "special cost studies," the manual sharply defines the difference between total costs as determined by any one of the three methods described, and the avoidable cost concept. The following statement brings this out nicely: "However, the point of analysis of marginal costs is to assess what costs will be added to, or deleted from, the total costs of the whole hospital due to the contemplated alternative. Only these are relevant to the decision since they measure the burden assumed or dropped by the hospital. The decisions about the recovery of costs are made on other bases."

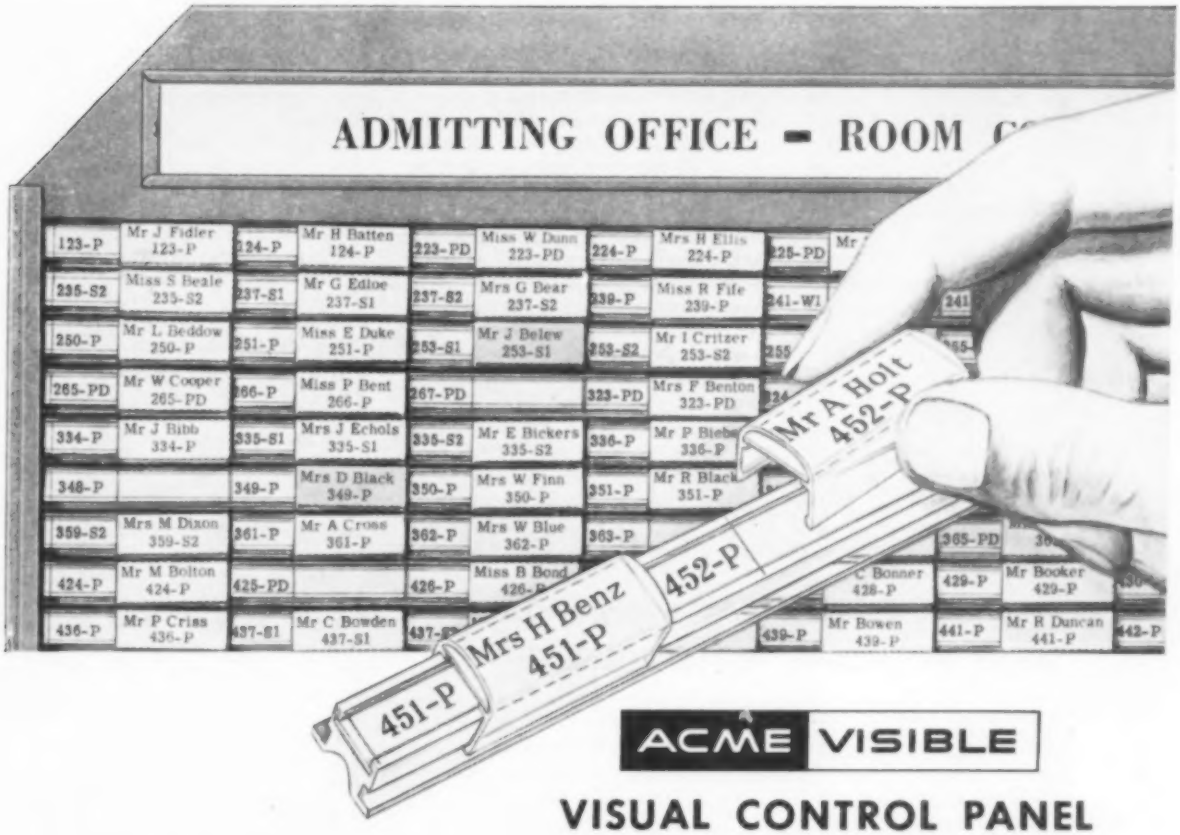
The following statement contained in the summary of this chapter is especially worthy of note: "Many situations will arise that will call for solutions that are not illustrated in this manual. However, use of the principles and procedures developed herein should assist in developing defensible solutions that will give adequate results. This chapter should serve to acquaint hospital management with the possibilities for special cost studies and serve as an impetus to greater use of this technic in the hospital field. In this way, management can make greater use of accounting procedures that are available to give information that will aid in the efficient operation of the hospital."

The final chapter of this excellent manual is devoted to "budgetary procedures in hospitals." Anybody who doubts the practicability of budgetary control in the operation of a hospital should have his doubts dispelled by this chapter.

Managerial use of budget data is well covered. Even though this manual should have been available for hospitals 10 years ago, the American Hospital Association committee that finally produced it has made a tremendously valuable contribution to hospital administration.—E. W. Jones.

THE FREEZING PRESERVATION OF FOODS. *Vol. II, Freezing of Precooked and Prepared Foods. By Donald K. Tressler, Ph.D., and Clifford F. Evers, B.S., M.S. Westport, Conn.: The Avi Publishing Company, Inc. Pp. 574. Illustrations, 126. Domestic, $10; foreign, $11.*

In this final addition to the foregoing comprehensive heading we have an entirely new book, one which assembles under one cover for the first time the current and authentic knowledge of the freezing preservation of precooked and "prepared" foods. These highly important items make



ACME VISIBLE

VISUAL CONTROL PANEL

ADMITTING OFFICE ROOM RECORD

Lightweight panels contain clear plastic tubes which are individually removable and may be shifted from one position to another . . . Clarity of tube provides full legibility of contents.

Inserts in plastic tube are typed with bed or room number. Color of insert indicates type of service—medical—surgical—obstetrical, etc.

Label holding plastic snap-on signal shows name of room occupant. Blank space clearly indicates "Bed or Room Available". Colored signal indicates "reservation".

Signals snap on or off at any point . . . Hold position until positively moved . . . Slide smoothly back and forth . . . Bypass freely . . . and, with insertable index, afford triple signalling: position, color or legend of index.

OTHER APPLICATIONS

- NURSES IN AND OUT
- NURSE TRAINING SCHEDULE
- BUDGET CONTROLS
- MAINTENANCE SCHEDULE
- OPERATING ROOM SCHEDULE

Ask the man from Acme to show you examples—

MAIL COUPON—TODAY!

ACME VISIBLE RECORDS, INC. CROZET, VIRGINIA

☐ Send us more information on Visual Control Panels.

☐ We are interested in Acme Visible equipment for H-258

_____ records.
KIND OF RECORD

☐ Have representative call. Date _____ Time _____

Company _____ Attention _____

Address _____

City _____ Zone _____ State _____

up the growing array of "convenience foods"—aptly so termed because they call for little more than one skip and a jump from the freezer to the table and little or no need for the dishpan thereafter.

This companion volume to the authors' earlier work will be as much or even more essential to the dietitian or other manager of food services; as labor problems intensify, more and more reliance will be placed on these convenience foods including as they do seemingly everything from hors d'oeuvres, soups, meat, poultry and fish dishes, specialty and nationality items, baked products, to frozen desserts and now even sandwiches. In fact the authors suggest that the greatest increase in frozen food production in the future will be in the precooked foods; one year, 1954-55, saw a 67 per cent increase. Specific directions, including proportions and methods, are given for all the foods now considered suitable for freezing. And fully as important, due attention is given to problems encountered in freezing, storage, packaging and transportation. A final chapter on food freezing and use of frozen food in public feeding establishments gives some idea of the extent to which these frozen foods are used in such institutions, with comments pro and con. Specifications, standards, inspection and test procedures appear in the appendix.—Mary P. Huddleson.

Care of the Long-Term Patient. *Volume II, Commission on Chronic Illness, Cambridge, Mass.: Harvard University Press, Pp.* 606. $8.50.

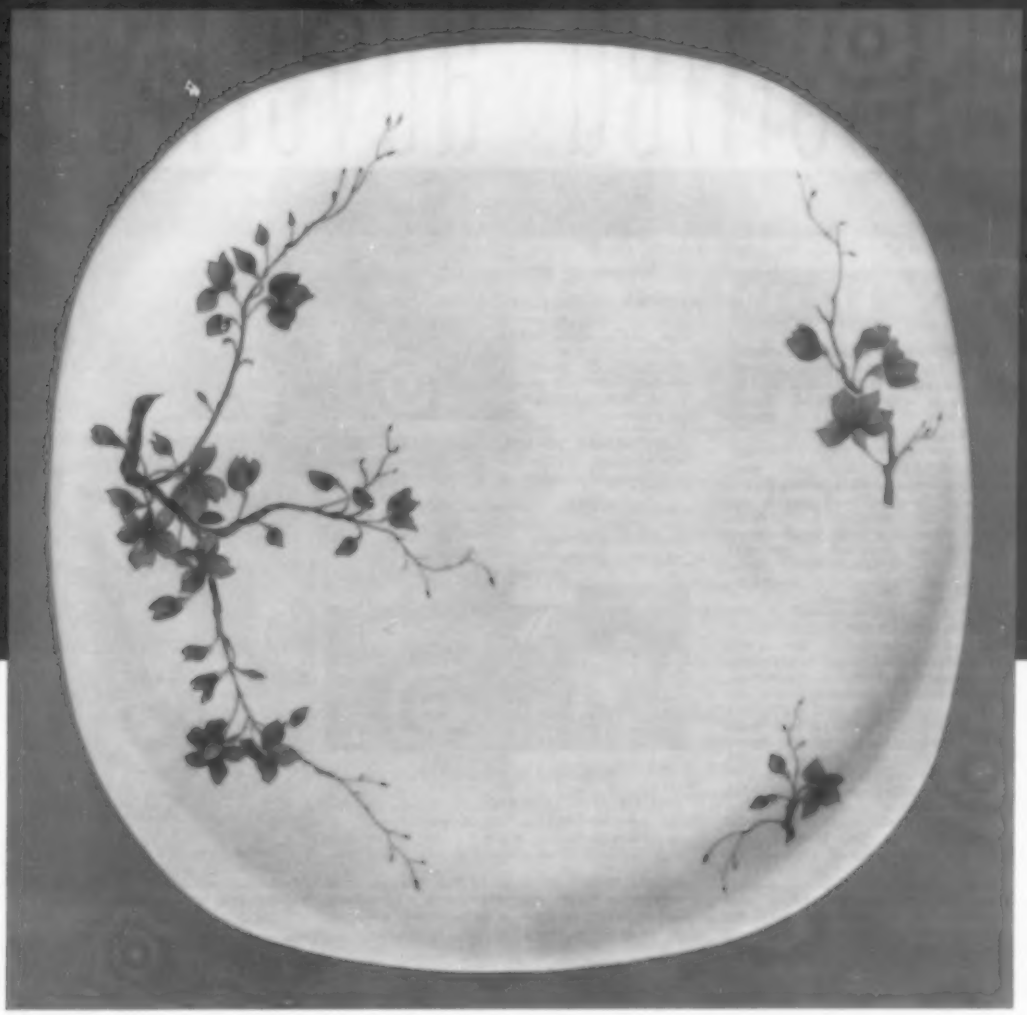
This volume, No. 2 in the definitive series published by the Commission on Chronic Illness, deals with the case of the long suffering patient whose heritage has been neglect, indifference and rustication. It is packed with valuable information on the subject though the conclusions, which might serve as a guide for institutional and community action, are still somewhat unclear and lacking in forthrightness.

The literature on the subject has become voluminous in the last decade, but this prolonged phase of illness has been impressing itself on the public largely through the increasing weight of sheer numbers, as well as long existing humanitarian need. Whatever the reason, this book proves that we now have the means to overcome three historic obstacles to reorganization: (a) diminishing interest on the part of the physician as chronicity takes hold; (b) medical indigence, which involves the poor patient in a vicious circle; and (c) lack of beds when the claim of the "chronic" is compared with the claim of the "acute."

A variety of new organizational and administrative remedies are reported here, but no other of them compares with the therapeutic organization recommended by this writer over three decades by which "acute" and "chronic" are integrated in the general hospital (supported by an extramural Home Care program) on a continuing basis, involving the coalescence of the medical and social points of view. It is gratifying to read in these pages that such integration is the most promising means of doing justice to the patient suffering from prolonged illness and that this plan of organization also satisfies the requirements of physician as well as social worker.

The bibliography might have been improved upon with a freer hand given to the scholar, for the benefit of the student who wants to read abbreviated passages *in extenso*. It seems a pity, but not a single contribution of this writer on the subject of prolonged illness (I do not refer here to Home Care) is identified anywhere in this volume, though its significance is visible on every page.—E. M. Bluestone, M.D.

To meet special needs . . .



BERKELEY
One of 23 Open Stock Patterns
In Syracuse China's
Hospitality Group
Packed in Cartons—Ready to Ship

The same number of conventionally shaped pieces you can get on a 16" x 22" tray can be placed on a 10½" x 15" tray when you use a Syracuse Trend service. Trend increases the capacity of your food service carts, lightens the load of school children's trays and offers perfect portion control. Syracuse China stands up better in actual use than any other china or china substitute.

No other line of china can match the beauty and performance of Syracuse

For descriptive literature write Dept. B-1

SAVES SPACE—CUTS COSTS FOR . . .


HOSPITALS


CAFETERIAS


SCHOOLS


TRANSPORTATION LINES

SYRACUSE China
SINCE 1871
SYRACUSE, NEW YORK

classified advertising

TERMS: 20c a word—minimum charge of $4.00 regardless of discounts. No charge for "key" number. Ten per cent discount for two or more insertions (after the first insertion) without changes of copy. Forms close 15th of month.

POSITIONS WANTED

ADMINISTRATOR—Eleven years executive level experience building, equipping, staffing, operating hospitals; B.S., A.C.H.A., 42, married, protestant; now employed. Apply MW 10, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ADMINISTRATOR—Anesthetist; male, married; 9 years experience as administrator-anesthetist in 32-bed hospital, considerable experience in planning, equipping and staffing new hospital; Member A.N.A.A. prefer same position in 30-50 bed hospital or business manager of clinic and anesthetist. Apply MW 11, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

BUILDING OR MAINTENANCE ENGINEER—Twenty-five years experience; ten years supervisory experience dealing with construction and maintenance contractors, tradesmen, preventive maintenance programs; heavy experience in electrical, heating, and ventilation equipment; have complete working knowledge of the various trades; member of the American Institute of Electrical Engineers and National Association of Power Engineers; willing to assume complete responsibility for new start-up or existing operation; present location New York State; age 51; would relocate. Apply MW 16, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

INDUSTRIAL ENGINEER—With work simplification training and experience in office procedures; industrial background. Reply to George Booth, 6234 Hoyne, Chicago 45, Illinois.

RADIOLOGIST—Certified, including isotopes; university trained; desires own department or association with older man; will limit to diagnosis or therapy. Apply MW 15, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE, CHICAGO

ADMINISTRATOR—B.S. (Education) M.S. (Hospital Administration); 6 years, assistant administrator, 350-bed general hospital; excellent experience in hospital construction; member, ACHA.

ADMINISTRATOR—Medical; four years, assistant director, 800-bed university hospital; eight years, administrator, 400-bed teaching hospital; FACHA.

ADMINISTRATOR—R.N.; degree in Hospital Administration; 16 years, director, 125-bed hospital, 6 years, 275-beds; FACHA.

ANESTHESIOLOGIST—Board qualified; since completing training, associate anesthesiologist, large teaching hospital, on faculty medical school.

COMPTROLLER—B.S. (Major: Accounting); since 1951, comptroller and office manager, 210-bed hospital.

MEDICAL BUREAU—*Continued*

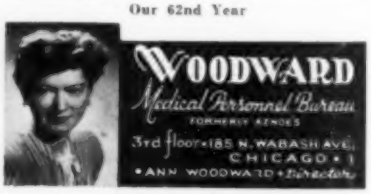
PATHOLOGIST—Diplomate; now completing 4 years' military service serving as pathologist, commanding officer; age 35.

PERSONNEL DIRECTOR—Master's in Psychology; in 1952 organized personnel department, 3000-bed hospital, since then has served as director.

PURCHASING DIRECTOR—B.S. Business Administration; six years, assistant administrator in charge of purchasing, 200-bed hospital.

RADIOLOGIST—Training in radiology, teaching hospital; 3 years, private and hospital practice; Diplomate.

Our 62nd Year



Telephone RAndolph 6-5682

ANESTHESIOLOGIST—Eight years, successful private practice, anesthesiology and attendant anesthetist, 600-bed teaching hospital; now requires warm climate; Diplomate, FACA.

EXECUTIVE HOUSEKEEPER—Early 50's; college trained; past 2½ years, full charge department, medium sized general hospital; seeks position large facility; midwest.

EXECUTIVE HOUSEKEEPER; 50's; over 20 years housekeeping experience, including 15 years, 300-bed hospital; seeks similar position; east preferred.

EXECUTIVE HOUSEKEEPER—Early 50's; almost 10 years' experience, including 5½ in 200-bed hospital, 2½ in 300-bed facility; southeast only, prefers Florida.

PATHOLOGIST—Fifteen years experience, tissue and clinical pathology; past 5 years, associate pathologist, 600-bed teaching hospital; seeks chiefship, midwest hospital offering research opportunity; Diplomate.

RADIOLOGIST—Southerner; trained Johns Hopkins; 3 years, associate radiologist, 300-bed hospital; any locality; AOA; Diplomate, diagnosis and therapy.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

EXECUTIVE HOUSEKEEPER—College education; 7 years business experience; 18 months housekeeping trainee; 300-bed western hospital.

ADMINISTRATOR—M.H.A. Degree, western university; Degree, Business Management, University of Michigan. 6 years business manager; 250-bed hospital.

ADMINISTRATOR—B.S. Degree, 1948, Hospital Administration. 6 years administrator; 100-bed Colorado hospital; 4 years administrator, 175 bed mid-western hospital; excellent references.

(Continued on page 161)

INTERSTATE—*Continued*

BUSINESS MANAGER—Degree in Accounting; 5 years experience, chief accountant large Ohio hospital; desires mid-western or western situation.

ASSISTANT ADMINISTRATOR—Age: 32 years; Degree, Social Sciences; M.P.H. Degree, 1954; administrative assistant, eastern institution, 3 years; any location.

POSITIONS OPEN

ANESTHETIST—Nurse; 40 hour week. Write Director of Nursing, Holy Cross Hospital, 4701 N. Federal Highway, Fort Lauderdale, Florida.

ANESTHETIST—Nurse; for 88-bed general hospital making plans to be enlarged to 125-beds; located at the world's most beautiful beaches; excellent working conditions, liberal personnel policy; enjoy living at year around resort center. Contact M. T. Mustian, Administrator, Memorial Hospital, Panama City, Florida.

ANESTHETIST—Nurse; for municipal hospital expanding to 200-beds; 4 major operating rooms, 1 minor operating room and cystoscopy room; salary open. Contact John M. Alexon, Administrator, Virginia Municipal Hospital, Virginia, Minnesota.

ANESTHETIST—Nurse; female; good salary, liberal fringe benefits; good hours; accredited 58-bed hospital. Apply to Superintendent of Allen Memorial Hospital, Oberlin College, Oberlin, Ohio.

ANESTHETIST—Nurse; two; 110-bed J.C.A.H. fully approved hospital; 1 immediate vacancy, 1 vacancy February 1st; anesthesiologist in charge of department; good personnel policies and salaries. Apply Dr. William Colantoni, M.D., Anesthesiologist, Brownsville General Hospital, Brownsville, Pennsylvania.

ANESTHETIST—Nurse; 60-bed general hospital, new building, modern equipment; western Wisconsin, college town, vacation, sick leave, retirement plan. Apply to H. C. Guntner, Manager, Memorial Hospital, Menominee, Wisconsin.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 N. Maryland Avenue, Milwaukee 11, Wis.

ASSISTANT DIRECTOR—Psychiatric and neurologic nursing, including service and education; salary upon request. Apply Director, Cook County School of Nursing, Dept. M., 1900 W. Polk Street, Chicago 12, Ill.

ASSISTANT DIRECTOR, NURSING SERVICE—400-bed general hospital affiliated with Chicago Medical School; progressive personnel policies; excellent salary. Write Director of Nursing, Mount Sinai Hospital, California Avenue at 15th Street, Chicago 8, Illinois.

Are you using the sealed-on patient identification that's so

Quick and easy to apply?

With Ident-A-Band, it's quick and it's easy to apply on-the-wrist identification that fits the individual wrist perfectly. Measure the wrist with the band itself. Punch hole for seal and tuck identity insert card *inside* the band where it's protected against alteration and moisture. Each "made-to-measure" Ident-A-Band goes on in seconds!

A smooth metal seal *permanently* locks the identifying data *inside* the Ident-A-Band. *That's* positive protection! Identifying data cannot be changed or the band removed without destroying the Ident-A-Band itself. The Hollister Sealing Instrument, especially designed to form this rivet-strong, permanent seal – *makes it easy* to apply.

A quick, rounding-off snip and the Ident-A-Band's ready to wear – for days or weeks or months. It's "made-to-measure" for comfort and safety, yet goes on in seconds. Only Ident-A-Band gives this permanently *sealed on* and *sealed in* protection . . . at a cost so reasonable that every hospital can easily afford it.

Ident-A-Band®

PREVENTS MIXUPS!

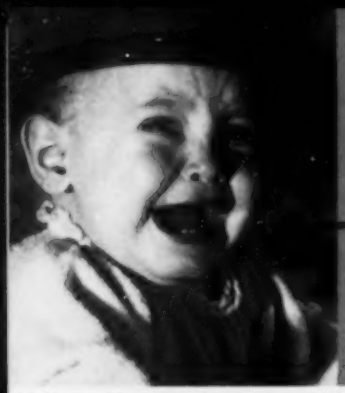
Patient's name, doctor's name, hospital number and other needed data are always in plain view on the patient's wrist. Ident-A-Band provides positive protection against mixups.

AND IT IS MOST ECONOMICAL

Only about a dime – a little more or a little less depending on annual usage – protects the patient against the hazards of misidentification. *Really protects* with the permanently sealed on-the-wrist identification proved on millions of patients. A letter or postcard will bring you complete information on Ident-A-Band. If you would like an identification survey and estimate for all-patient protection in your hospital, include approximate annual number of OB, pediatric and adult admissions.

FRANKLIN C. HOLLISTER CO.

833 N. ORLEANS STREET, CHICAGO 10, ILLINOIS



Fightin' Mad

Babies are up in arms — and so are many OB nurses and supervisors — about messy ink-pad and roller methods of taking footprints. Who wants horse 'n' buggy methods in a modern hospital?

Mighty Glad

So glad the modern, clean-as-a-whistle way of footprinting has come to stay! No gummy ink to smear tiny tootsies with the Hollister Dry-Plate FootPrinter.

1 No mess...just press!

No roller! No inking! Hollister "Dry Plate" FootPrinter yields perfect baby prints.

2 Apply foot to chart!

That's all you do to get clear prints of the tiniest lines and whorls.

the FootPrinter by Hollister

makes perfect prints without messy ink

. . . and never underrate the importance of perfect footprints of all babies born in your hospital!

AS SOUVENIRS — Cute little prints of newborn on the back of a Hollister *Inscribed* Birth Certificate please parents and make the certificate more than ever a treasured keepsake.

AS RECORD PRINTS — Sharp, clear, *identifiable* footprints of the baby and a thumb print of the mother are invaluable as permanent records of identity. Prints are taken in the delivery room as recommended by the A.H.A., and become a part of the mother's chart. They provide positive lifetime proof of identity — offer protection for the hospital and for the patient should questions of identity arise.

But bear in mind . . . only prints that clearly show ridge formation aid in identification. In recent tests made by identification experts, 100% of the prints taken with a Hollister FootPrinter showed ridge formation. And 84% were fully identifiable! The Hollister FootPrinter proved more than twice as effective as the next best method tested!

Only $9.50 buys a FootPrinter with FREE Magnifier for checking print quality. Write for one today.

Franklin C. Hollister Company, 833 N. Orleans Street, Chicago 10, Illinois

3 Whisk soil away!

A quick, light sponging removes the last trace of color from baby's foot. Easy!

classified advertising

POSITIONS OPEN

DEPARTMENT HEAD—Large central supply department; logistic responsibility for all equipment and supplies in care of patients; qualified hospital administration course graduate, professional nurse or college prepared lay person. Contact Director of Personnel, The Johns Hopkins Hospital, Baltimore, Maryland.

DIETITIAN—Must be A.D.A. member; 95-bed enlarging to 130-beds with school of nursing good personnel policies; 40-hour week; hospital fully approved by J.C.H.A.; salary open. Apply MO 216, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

DIETITIAN—Chief; modern teaching hospital in Boston area has opening for chief dietitian; applicant must have administrative experience at least as assistant chief level; must supervise large department including teaching and therapeutic dietitians and food service supervisors; excellent opportunity; salary open. Write giving details to Personnel Director, New England Medical Center, 37 Bennet St., Boston, Massachusetts.

DIETITIAN—Excellent opportunity for ADA registered, hospital-trained person in therapeutic or administrative dietetics; salary commensurate with training and experience; chances for promotion excellent; liberal benefits. Apply Personnel Director, Iowa Methodist Hospital, Des Moines, Iowa.

DIETITIAN—Therapeutic; Borgess Hospital, 340-bed general hospital; duties include cafeteria, therapeutic diet planning, patient contact, general supervising and teaching student nurses; a large full-time medical staff and house staff; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—College graduate, salary range $3800-$4740, forty-hour week, liberal employee benefits. Apply Personnel Director, Ancora State Hospital, Hammonton, New Jersey.

DIETITIAN—A.D.A. or equal; full charge of department in 55-bed general hospital, modern kitchen, excellent conditions, salary open. Apply Administrator, Lakeview Memorial Hospital, Bath, New York.

DIETITIAN—Chief; top level position, excellent opportunity; modern 230-bed hospital expanding to 320; applicant must have administrative experience; salary open. Send full details and photograph to Superintendent, Bethesda Hospital, Oak Street and Reading Road, Cincinnati 6, Ohio.

STAFF DIETITIAN—Therapeutic; A.D.A. member, to counsel and teach patients; hospital recently expanded to 450-beds, located in desirable residential district; approved by Joint Commission; dietary facilities entirely new and air conditioned; dietetic program integrated with approved school of nursing, affiliated with Medical Research Institute 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

DIETITIANS—All levels, for large center-city hospital; salary open. Write, giving experience, to Personnel Director, Jefferson Hospital, 10th & Sansom Streets, Philadelphia 2, Pennsylvania.

DIRECTOR OF NURSES—B.S. degree in Nursing Education and experience or Masters Degree; salary open, 40-hour week, good personnel policies; hospital fully approved by J.C.H.A. Apply MO 215, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING SERVICE—Expanding 300-bed West Coast hospital, metropolitan location; salary open; desire candidate with 2 years demonstrated progressive administrative experience plus MA in Nursing Administration, or 6 years comparable experience. Write MO 218, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES — Ultra-modern 220-bed J.C.A.H. approved general hospital opened in 1952; new nurses residence nearly completed, Bachelor degree required. Masters degree desirable; forty-hour week, ideal working conditions; salary open; excellent personnel policies, social security, and group hospitalization; attractive college town of 25,000 population, close to Estes Park and Denver; immediate opening. Apply H. H. Hill, Administrator, Weld County General Hospital, Greeley, Colorado.

DIRECTOR OF NURSING—Excellent opportunity for person with head nurse, supervisor or administrative supervisor experience; B.S. degree desired; to organize and develop present service, plan for new hospital; complete responsibility, pleasant job environment. Opportunity to work toward master's degree; salary $6000 to $6600. Apply Bethesda Hospital, North Hornell, New York.

DIRECTOR OF NURSING—If you are looking for a challenging opportunity we would like to hear from you; we are a 92-bed general community hospital serving a densely populated area, located in northeast Cleveland, 40-hour week, social security, liberal vacation. Write, giving full particulars on experience to J. C. Gliemmo, Director, Forest City Hospital, 701 Parkwood Drive, Cleveland 8, Ohio.

DIRECTOR OF EDUCATION — NLN accredited diploma school; basic sciences taught Amarillo College; total enrollment 100; forty hour week, salary commensurate with qualifications; hospital JCAH; 230-beds; expansion program in process, city population 150,000. Apply Mrs. Wanda Reed, Northwest Texas Hospital, Amarillo, Texas.

DIRECTOR—NURSING SERVICE AND EDUCATION—300-bed Protestant general hospital, expansion program in progress, with 150-student Schoo. of Nursing, needs director of nursing to be responsible for nursing service and school of nursing; applicants should be in excellent health, between approximate ages of 35-45; liberal salary range and benefits; excellent working conditions in one of the midwest's foremost institutions, centrally located in the city and convenient to outstanding residential and shopping facilities. Contact Mr. S. W. Martin, Administrator, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

INSTRUCTORS—Clinical; for operating room technique and in medical and surgical nursing, day, evening and night shifts; integrated program; affiliated with Drake University; 200 students in school; 400-bed, fully approved, non-profit hospital; minimum qualifications: B.S. degree, preferably in nursing education; salary open, 40 hour work week; 20 working days vacation; sick benefits; position open immediately. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

INSTRUCTOR OF NURSES—B.S. Nursing Education, salary range $4560-$5460; new nurses' home, liberal employee benefits. Apply Personnel Director, Ancora State Hospital, Hammonton, New Jersey.

INSTRUCTOR—Clinical; medical-surgical formal and clinical teaching in NLN temporary accredited diploma program; integrated course correlated with other courses over a 39-week period during the first year; no service responsibilities, permissive atmosphere for joint planning and function; B.S. degree required; liberal personnel policies, salary commensurate with experience and preparation. Apply to Director, School of Nursing, Memorial Hospital, Pawtucket, Rhode Island.

INSTRUCTOR — Clinical; operating room; NLN accredited diploma school; assist operating room supervisor and teach formal and clinical classes for professional students; salary commensurate with qualifications; 40 hour week. Apply Mrs. Wanda Reed, Northwest Texas Hospital, Box 1110, Amarillo, Texas.

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

MEDICAL DIRECTOR — Assistant; 114-bed tuberculosis hospital, salary $8500-$9500 per year plus complete maintenance including apartment, food, laundry, and utilities. Apply Executive Director, State Tuberculosis Commission, New Capitol Annex, Frankfort, Kentucky.

MISCELLANEOUS — Assistant Director of Nursing Service; available immediately; salary $423.00-$523.00. Staff Dietitian; available February 1, 1958; salary $342.00-$423.00. X-Ray Therapy Technician available March 1, 1958; salary $325.00 - $401.00. Occupational Therapist; one position available immediately and one position available February 1, 1958; salary $342.00-$423.00. Physical Therapist; available March 1, 1958; salary $361.00-$446.00. Apply Personnel Department, Monterey County Hospital, P.O. Box 1611, Salinas, Calif.

MISCELLANEOUS—Positions vacant at The Montreal Children's Hospital; Assistant Executive Director; must be a medical graduate and preferably a graduate of a hospital administration course. Administrative Dietitian; Please apply to Dr. J. E. de Belle, Executive Director, The Montreal Children's Hospital, 2300 Tupper Street, Montreal 25.

NURSES—Operating room and staff; for 227-bed pediatric hospital in sunny California; salary $315 per month with differential for operating room and evening and night duty; 5 day, 40 hour week; liberal personnel policies including vacation, sick time and retirement. Apply Director of Nursing, Childrens Hospital Society, 4614 Sunset Blvd., Los Angeles 27, California.

NURSING—Staff; annually $3000 to $3360 plus two meals daily and uniform laundry, six paid holidays, liberal sick leave and vacation. Apply Director of Nursing, Episcopal Eye, Ear and Throat Hospital, 1147 15th St., N.W., Washington 5, D.C.

(Continued on page 162)

classified advertising

POSITIONS OPEN

NURSE—Registered; 34-bed modern hospital in southwestern Colorado approximately 4500 population, 40-hour week, 2 weeks paid vacation, 12 days paid accumulative sick leave, 4 paid holidays, social security benefits, semi-annual raises, Blue Cross and Blue Shield, optional meals and laundry furnished; substantial differential for night duty; starting salary $310 per month. Contact Administrator, Community Hospital, Monte Vista, Colorado.

NURSES—Staff; immediate opening, new ultra modern 220-bed J.C.A.H. approved general hospital; new nurses residence nearly completed; forty-hour week, $285 starting salary with $10 additional for evening and nights, good chance for advancement and experience in surgery and obstetrics, excellent personnel policy, good working conditions, social security, attractive college town of 25,000 population, close to Estes Park, Denver and Colorado Springs; ideal climate, skiing, boating, etc. Apply Director of Nurses, Weld County General Hospital, Greeley, Colorado.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

NURSES—Staff; 200-bed hospital, 40 hour week; vacancies for graduate and practical nurses for operating room, recovery room, obstetrics, emergency room, delivery room, medical and surgical nursing. Apply to Director of Nurses, St. Mary's Hospital, West Palm Beach, Florida.

NURSES—Staff; staff positions in all clinical areas including psychiatry, poliomyelitis and respiratory center in new, 800-bed air conditioned hospital; 40-hour week; 3 weeks vacation annually; beginning salary; staff nurses, $275 monthly; periodic increments; opportunity for college study through bachelor's degree program. Write Director of Nursing Service, Eugene Talmadge Memorial Hospital, Medical College of Georgia, Augusta, Georgia.

NURSES — Registered; psychiatric hospital; liberal personnel policies; 40-hour week, attractive residence; positions available on all shifts; differential salary for evening and night service. Inquire Director of Nurses, Essex County Overbrook Hospital, Cedar Grove, New Jersey.

NURSES—Staff; for 85-bed general hospital; beginning salary $300 per month; $10 differential; 38 hour week, living accommodations available. Please apply St. Ann's Hospital, Juneau, Alaska.

NURSES—Registered; for staff duty, all departments; also supervisory and instructional positions open; 674-bed general hospital located in industrial city (500,000 population); liberal personnel policies; 40 hour week. For further information apply to Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Men and women; in residential treatment center for emotionally disturbed and psychiotic children; opportunities for entering relatively new field; offers in service training; rating in accordance with experience. Contact Dorothy Johnston, M.D., Allentown State Hospital, Allentown, Pa.

NURSES—Psychiatric; for supervising psychiatric buildings and atttendants; mature experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

PHYSICIAN-SURGEON preferred, or physician to establish own independent practice in City of Wakefield, Michigan; approximately 3,500 population, located in Gogebic County near western part of Upper Peninsula; modern, fully equipped office for sale near new 60-bed hospital. Contact City Clerk, Wakefield, Michigan.

SUPERVISOR-INSTRUCTOR — Operating room; 209-bed general hospital; NLN fully accredited school of nursing; 96 students; 40 hour week; special clinical preparation in operating room supervision; salary open, liberal personnel policies. Apply Director of Nursing, Middlesex Memorial Hospital, Middletown, Connecticut.

SUPERVISOR—Operating room; 200-bed hospital, 40 hour week; salary commensurate with experience and qualifications. Apply to Directress of Nurses, St. Mary's Hospital, West Palm Beach, Florida.

SUPERVISOR—Assistant; in operating rooms; 300-bed hospital; adequate, modern equipment; 40 hour week; 20 paid days vacation, cash salary; liberal personnel policies; preparation and experience desired; salary open. Apply, Director of Nursing, Mercer Hospital, Trenton, New Jersey.

SUPERVISOR—Operating room; NLN accredited diploma school; 230-bed general hospital; average 20 operations daily; 40 hour week, salary commensurate with qualifications. Apply Mrs. Wanda Reed, Northwest Texas Hospital, Box 1110, Amarillo, Texas.

SUPERVISORS—Registered nurse; 35-bed general hospital; starting salary: 7-3, $320; 3-11, $330; 11-7, $340; liberal personnel policy. For further information write Memorial Hospital, Pecos, Texas.

TECHNOLOGIST—Laboratory; 250-bed hospital; salary open. Apply MO 171, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNICIAN—Laboratory; male or female; ASCP only; reorganized general hospital laboratory in modern, fully approved hospital, near Boston; requires services of "better than average" technician; salary $3800 to $4000, with opportunities for advancement. Apply by letter to MO 217, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNICIAN—Laboratory; with knowledge of X-ray; salary open. Apply Wayne County Hospital, Corydon, Iowa.

TECHNICIAN—Registered X-ray and laboratory; to head both departments, male or female; beginning salary suggested $390.-$400., commensurate with experience. For further details contact Administrator, Esther M. Squire, Murphy Memorial Hospital, Red Oak, Iowa.

(Continued on page 164)

TECHNOLOGIST — Medical; TB Sanatorium near Duluth, Minnesota; quarters, hospitalization, sick leave, retirement benefits; no call duty; A.S.C.P. registration required. Write Superintendent, Nopeming Sanatorium, Nopeming, Minnesota.

TECHNICIAN — Laboratory; 236-bed general hospital 30 miles from New York City; interesting position with advancement in progressive hospital. Contact Personnel Office, Morristown Memorial Hospital, Morristown, New Jersey.

TECHNICIAN—X-ray trained; required to manage one man radiology department, doing routine radiography and electrocardiography in U.S. town of 5000; salary commensurate with experience. Contact Leon Bennett-Alder, North Country Hospitals, Gouveneur, New York; Telephone 950.

TECHNOLOGISTS—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

TECHNICIAN — Laboratory and X-ray; for small hospital in Wyoming, 5 day week subject to call every other week; must be willing to help in record room and office; salary depending on qualifications and ability. Apply Administrator, St. John's Hospital, Jackson, Wyoming.

OCCUPATIONAL THERAPISTS — Opening for a chief occupational therapist at a tuberculosis hospital under the City of St. Louis; pay range is $381 to $464 per month; staff therapist openings at other City hospitals at pay range of $329 to $401 per month. Write to Department of Personnel, City of St. Louis, Room 235, Municipal Courts Building, St. Louis 3, Missouri.

ADMINISTRATORS—(a) 400-bed, fully approved hospital; one with degree or good experience; very lucrative, salary basis; large city; pleasant climate. (b) Requires degree HA, PA or Bus Adm, 4 years experience or equivalent; 360-bed hospital; $12-14,820; California. (c) Requires 8-10 years experience; hospital 150-200 beds; $10-12,000; lovely town, southeast. (d) Medical; 200 bed, general hospital; should be associated with ACHA; east. (e) 2 new units, general acute hospitals, 125-beds; range $10-15,000; large university city, midwest. (f) Medical director; large teaching hospital, unit university medical center; to $15,000, home, utilities; east. (g) To direct medical education program; experience graduate field helpful; large hospital; midwest. (h) New hospital, 100-beds enlarging to 200-beds, to be constructed; financial arrangements open; midwest. (i) Department of Health; requires either MPH, MPHA, MHA, with some experience public health work; one of larger cities, Alaska; $7500. (j) Direct 60-bed hospital and act as consultant in opening 4 additional small hospitals; will direct each hospital as they open; requires at least Nominee ACHA; Southern Calif.; $15,000 for one well-qualified.

classified advertising

POSITIONS OPEN

WOODWARD—*Continued*

ASSISTANT ADMINISTRATORS—(k) Requires Hospital Administration degree and one year's experience; 230-bed hospital; university city, 200,000; West Mountain State; about $6,600 with increases. (l) Large size, fully approved hospital, outstanding facility; training program; Pacific Island; medical administration. (m) Qualified to assume administrative functions in absence of director; fairly large hospital, near Pittsburgh. (n) Requires degree in Hospital Administration or three years experience as assistant administrator; 2000-bed hospital; $6060-$7356; near Los Angeles. (o) 185-bed hospital, teaching program; about $7500; large city on Lake Michigan.

ADMINISTRATIVE ASSISTANTS—(p) Division of patient care, 300-bed hospital; $5880-$6468; university city, southwest. (q) 200-bed hospital; requires one who has completed residency, perhaps 1 or 2 years experience; about $5000; Washington, D.C., area. (r) 325-bed, medical school affiliated hospital; if MPH or with health agency experience, $6000; northeast.

ADMINISTRATIVE POSTS—(s) Comptroller; between 35-40 with hospital experience; 350-bed hospital; one of finest medical centers; to $10,000; southwest. (t) Clinic manager; 8 man group; $7200 start; midwest. (u) Credit manager, 150-bed hospital; should have 1 or 2 years experience, and know business and legal aspects of collection work; $4400-5600; midwest.

EXECUTIVE HOUSEKEEPERS—(a) Stable, dependable woman to age 50; full charge department, 250-bed hospital and 120-bed nurses home; about $4200; large city, university community; midwest. (b) Excellent opportunity to head department, nationally known large facility; noted university, industrial center; southeast; highly recommended. (c) Head department, 3 tuberculosis hospitals, total over 1700-beds; $4200 start, to $5400 in 5 yrs.; south. (d) Supervise 50 and reorganize department, 400-bed voluntary general hospital; popular summer, winter resort area, college city; California. (e) Full charge, 250-bed general hospital; large New England college city.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS—(a) Medical, to succeed administrator retiring after long tenure; fully approved general hospital, 700-beds; east; next autumn. (b) Assistant medical director; 450-bed general hospital; duties include directing residency program; attractive location, outside U.S. (c) Direct, new 400-bed general hospital; resort city, south. (d) Direct, 375-bed general hospital, California. (e) Direct, new community hospital, 300-beds; university city, east. (f) Assistant; 250-bed hospital; teaching facility for university medical school; west. (g) Assistant; 200-bed general hospital; preferably course graduate with some experience; medical school city, east. (h) Woman, preferably R.N.; 80-bed hospital; building program; resort town, New York. MH2-1

ANESTHETISTS—(a) Instructor, anesthesiology program for student nurses; 500-bed hospital; midwest. (b) Staff; no OB; 130-bed

MEDICAL BUREAU—*Continued*

hospital, Colorado; $550. (c) Two, one OB, one surgery; 200-bed hospital; Florida resort; $6000. (d) Association, group of medical anesthesiologists; near Cincinnati; $7680. MH2-2

DIETITIANS—(a) Chief, 200-bed hospital; atomic research center; $6000. (b) Chief; 225-bed hospital; expansion program to 325; latest equipment; centralized service $6-8000; midwest. (c) Assistant with ability assume full responsibility; university dining hall for 1000 co-ed students, midwest; $5000. MH2-3

DIRECTORS OF NURSING—(a) Director of Nurses; large hospital; all graduate staff; exceptional ability administration, reorganization required; West Coast; to $12,000. (b) Director of Service and School; 350-bed hospital; expansion program; near New York City; $10,000. (c) Directors of Nurses (2); 60-80 bed hospitals; ideal northern, southern California; $6000. (d) Director School and Service; 600-bed, new, modern hospital; New England City near Cape Cod resorts; salary commensurate ability. (e) Direct small school of nursing, Pacific Island natives. MH2-4

EXECUTIVE PERSONNEL—(a) Comptroller; 375-bed general hospital; university city, southwest; $8-10,000. (b) Credit manager; 250-bed hospital; Florida. (c) Food service supervisor; 450-bed hospital; university city, midwest; top salary. (d) Personnel director; teaching hospital, 1000-beds; university city, east; $9-10,000. (e) Purchasing agent; 300-bed general hospital; California. MH2-5

EXECUTIVE HOUSEKEEPERS—(a) Teaching hospital, 450-beds; expansion program; university town near Chicago; $6000, up. (b) Large hospital, Greater Manhattan; preferably male with hotel experience. MH2-6

FACULTY POSTS—(a) For respirator, rehabilitation center, college of nursing; rank, assistant professor; $5000; south. (b) Director state public school of practical nurses, midwest; $6000. (c) Associate professor pediatrics; State College of Nursing; south; to $8800, academic year. (d) Chairman of nursing research renowned university; doctorate or eligible; east; academic year. MH2-7

MEDICAL RECORD LIBRARIANS—(a) Chief, 220-bed hospital; 18 in department; $5200; west. (b) Chief, 300-bed hospital; well equipped department; congenial associates; commuting distance New York City; to $6000. MH2-8

SUPERVISORS—(a) OR to head nursing services, 70-bed hospital; northern California; exceptional opportunity for growth; to $500. (b) OB; no teaching; 150-bed hospital; beautiful upper state New York; $5500. (c) Outpatient clinic; supervise 8 nurses; student nurses; medical center; midwest; to $435, meals, laundry. (d) Night supervisor; 200-bed hospital near New York City; to $400. MH2-9

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—(a) 160-bed general hospital; progressive hospital in eastern teaching center. (b) 56-bed Ohio hospital; $8400. (c) 75-bed hospital, Virginia. (d) 40-bed new hospital, midwest; open March.

ADMINISTRATIVE ASSISTANT—(a) 170-bed hospital, north central state; college community. (b) 200-bed hospital, New York State. (c) 200-bed hospital, east; MHA degree. (d) R.N., 140-bed hospital; Pennsylvania.

(Continued on page 166)

INTERSTATE—*Continued*

BUSINESS MANAGER—(a) Head accountant; 180-bed hospital; south. (b) Small Colorado hospital. (c) 400-bed hospital, New Jersey. (d) Credit manager; 300-bed Ohio hospital.

DIRECTOR OF NURSING—(a) 250-bed hospital, Ohio; $7200, maintenance. (b) 250-bed hospital; east. (c) Assistant directors, nursing service; $6000.

MEDICAL RECORD LIBRARIANS—(a) 275-bed hospital; Pennsylvania. (b) Specialized hospital; California; $436. (c) 175-bed Ohio hospital.

TECHNICIANS—(a) Laboratory; $450. (b) Bio-Chemist; $550. (c) X-ray; laboratory-x-ray; midwestern hospitals.

EXECUTIVE HOUSEKEEPERS—(a) 185-bed hospital; Pennsylvania. (b) 250-bed hospital; midwest. (c) 275-bed hospital; east. (d) Assistant housekeeper; large hospitals; New York State, California.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

EXECUTIVE PERSONNEL—(a) Controller; southwest; 350-bed hospital; $10,000. (b) Personnel director; middle west; 400-bed hospital; $6000 minimum. (c) Credit collection manager; east, 425-bed hospital; $5500. (d) Administrative assistant; south; 200-bed hospital; $5000.

DIRECTORS OF NURSING—(a) California; 75-bed hospital; B.S. degree preferred; $7200. (b) New England; 225-bed hospital in seacoast city of 50,000; $7200. (c) East; 500-bed hospital; to $10,000. (d) South; 175-bed hospital in city of 35,000; $6000 plus maintenance. (e) Assistant; middle west; 200-bed hospital; $6000.

DIETITIANS—(a) Chief; 250-bed hospital near Chicago; $6000. (b) Chief; California; 100-bed hospital; $5400 up. (c) Chief; east; 175-bed hospital; two well trained assistants; $6000. (d) Food production supervisor for food service organization; train new dietary personnel; degree in Home Economics; $6000. (e) Therapeutic; west; 135-bed hospital; $4800.

SOCIAL SERVICE WORKERS—(a) Consultant for Public Health Agency; West Coast; prepare policies and standards, coordinate program with community social agencies, etc.; $6000. (b) Chief; psychiatric; social worker; Master's degree; 5 years experience; $7800 plus house and utilities. (c) Medical social worker; prefer at least 2 years experience; 175-bed general hospital near New York City; $5000 minimum. (d) Senior psychiatric social worker; south; guidance clinic for children and adults in city of 120,000; $6900.

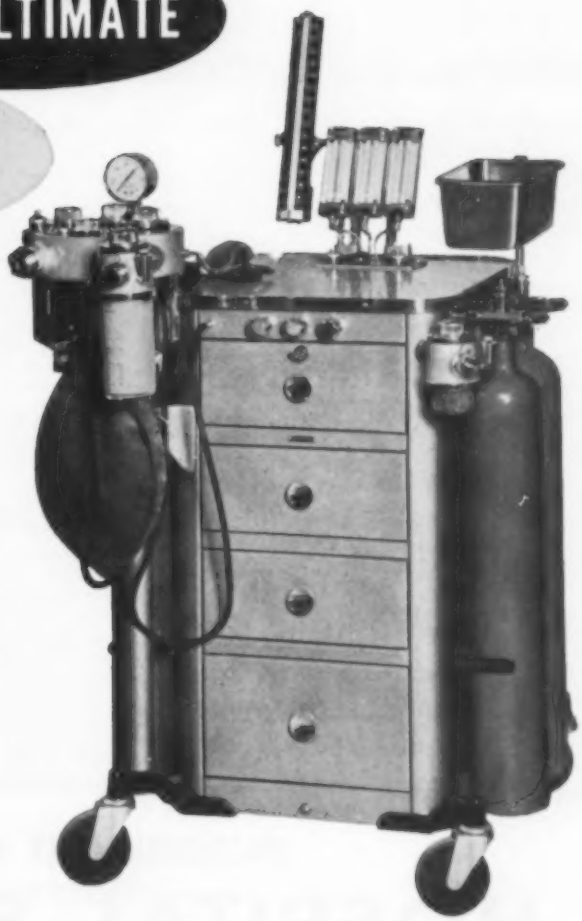
MEDICAL EMPLOYMENT SERVICE
59 East Madison Chicago 2, Ill.
ANdover 3-5663-64
Alfred E. Riley, R.N., MSHA Director

ADMINISTRATORS — (a) 100-bed hospital, midwest, salary $12,000. (b) 125-bed hospital, New England; salary $9,600. (c) 50-bed hospital, Missouri; salary $7,200. (d) 75-bed hospital, South Carolina; $6,500. (e) Large Psychiatric hospital; must have experience and MS degree in Hospital Administration; $10,000 to 14,000. (f) 100-bed hospital, south; salary $7,500. (g) 100-bed hospital; northwest; salary $8,500.

THE ULTIMATE

in modern anesthesia equipment

NEW McKESSON CABINET MODEL



- Supplied with any combination of gases now in use.
- Equipped with bi-phase flow meters.
- Flow-rate controls mounted on front for utmost operating convenience.
- Twin Canister Absorber with 1800-gram baralyme capacity.
- Bag-Pressure Gauge shows pressure of gases in circuit at all times.
- Direct Oxygen Button for immediate oxygen under pressure.
- Direct Nitrous-Oxide Button for quick refilling of nitrous bag.
- Large storage capacity in four locking drawers.
- Stainless steel top and heavyweight steel construction.
- Finished in green enamel, trimmed with chrome-plated parts.
- Supplied with wide variety of accessories.

McKesson

NEW CABINET MODEL

For prices, other features and full details, write for McKesson Cabinet Model literature.

McKESSON APPLIANCE COMPANY • TOLEDO 10, OHIO

classified advertising

POSITIONS OPEN

MEDICAL EMPLOYMENT—*Continued*

ASSISTANT ADMINISTRATORS—(a) Large hospital, Michigan; must have MS degree plus purchasing experience; salary open. (b) 150-bed hospital, east; salary $5,400; MS degree preferred. (c) 350-bed hospital, Kentucky; MS degree preferred; salary open; wonderful opportunity to applicant completing administrative residency in hospital administration. (d) Several hospitals in California; salary range $500 to $600 per month.

NURSE ANESTHETISTS—(a) Large Teaching Hospital; salary $600 per month for 40 hour week; overtime for extra duty; male or female. (b) Male nurse anesthetist to act as administrator and in charge of anesthesia of a 40-bed hospital; salary open.

LABORATORY TECHNICIANS — (a) Chief technician, Metropolitan Chicago area; salary $500 per month; 40 hour week, extra for overtime. (c) Laboratory technician, senior, must be ASCP registered; $400 per month; bio-chemist, MS or Ph.D. level, $600 per month, Illinois. (d) South. ASCP or AMT; Salary $300.

EXECUTIVE PERSONNEL—(a) Credit & collection manager, east; $5,400. (b) Food service manager, administrative 400-bed hospital; New York; must have had previous hospital experience; salary $7,200. (c) Purchasing agent; 300-bed hospital, New England; salary open. (d) Personnel Director, Illinois; salary $7,200.

DIRECTOR OF NURSES AND EDUCATIONAL DIRECTORS—All areas; many hospitals are now considering new appointments for June 1st; salary ranges $6,000 to $12,000; many will pay commission fee.

MEDICAL RECORDS LIBRARIANS — Chief librarians, several hospitals in the south, 2 in Texas, several in Illinois; salary ranges from $400 to $500 per month.

DIETITIANS — Administrative and therapeutic; all areas; commission fees paid; salary range $400 to $600 per month.

PLACEMENT BUREAUS

INDIANA MEDICAL BUREAU
212 Bankers Trust Bldg.
Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

(Continued on page 168)

PLACEMENT BUREAUS

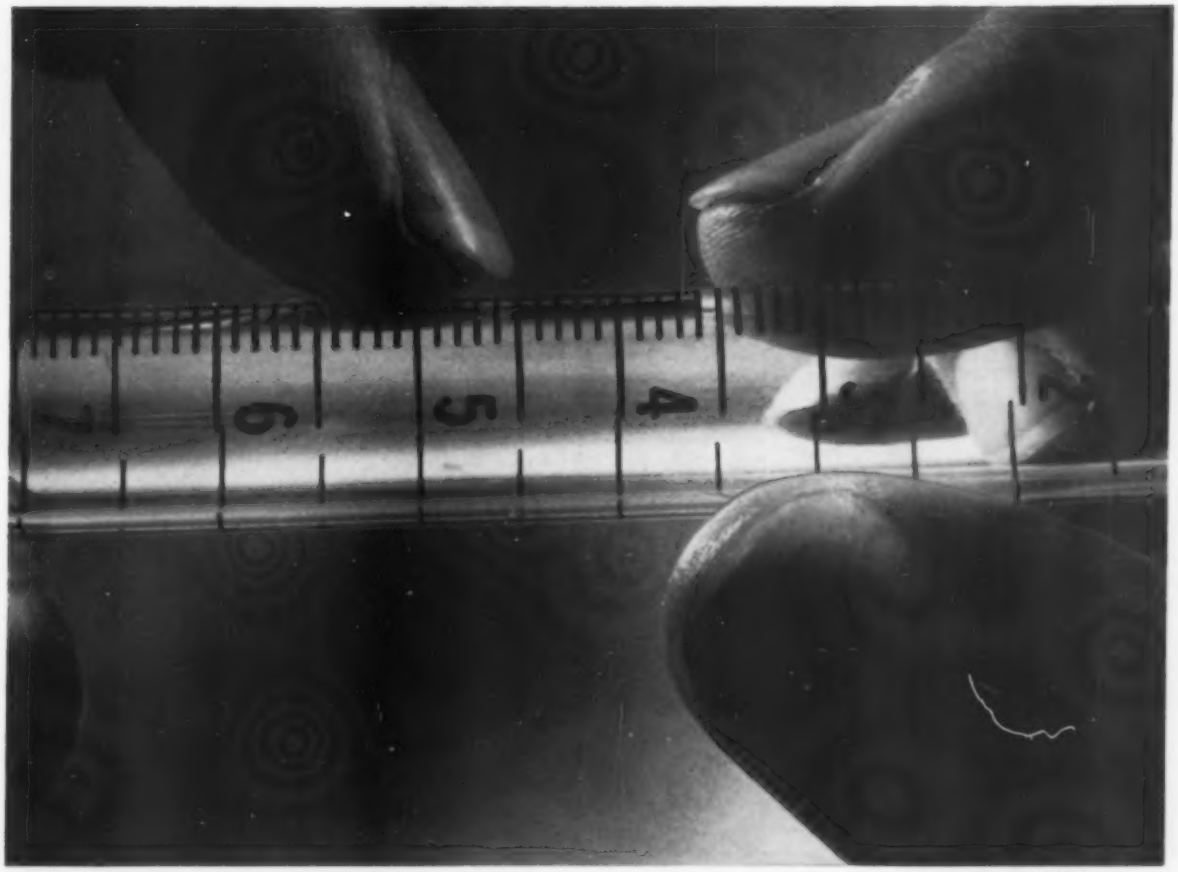
MARY A. JOHNSON ASSOCIATES
11 West 42 Street New York 36, N.Y.
Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee
Agency



Enlarged 2½ times

Rub an Accu-red pipette— you'll feel why it lasts longer

Accu-red graduations are something new and unique in pipettes.

The graduations are right *in the glass*. As you rub you'll notice a smooth surface. A smooth pipette can take more punishment.

Accu-red graduations are as permanent *as the glass itself*. Prove it to yourself by briskly rubbing them with emery cloth. The surface of the glass will scratch but the graduations are unimpaired.

Cleanable? Use any common acid or cleaner, rinse and sterilize. Made of glass No. 7740, these PYREX pipettes will take many trips through the washer.

Accurate, too. For example, capacity tolerance of the 1 and 2 ml Accu-red pipettes is ±0.02 ml.

Cost 15% less. Even with their wearproof graduations and accuracy, these pipettes cost you 15% less than previous designs of comparable accuracy.

Easy to read. Split sight lines level with major graduations to reduce parallax in readings.

Won't contaminate. Glass No. 7740 doesn't in any way alter antigens, or biological or serological solutions.

You can get Accu-red pipettes from your laboratory supply dealer in these sizes: Serological and Mohr types in 1, 2, 5, and 10 ml and a 25-ml Mohr type.

CORNING GLASS WORKS
38-2 Crystal Street, Corning, N.Y.
Corning means research in Glass

PYREX

PYREX® laboratory ware
. . . the tested tool of modern research

classified advertising

PLACEMENT BUREAUS

Specialists for private duty placement in Hospitals and Homes.

655 Sutter Street

San Francisco

Gr-4-7005

A-1 NURSES REGISTRY

6087 Sunset Blvd.

Los Angeles

Ho. 2-7292

Cr. 4-7255

Po. 3-7369

We invite inquiries.

A licensed and bonded Professional Nurses Agency.

DOROTHEA BOWLBY ASSOCIATES

8 South Michigan Avenue Chicago 3, Ill.

Suite 618—ANdover 3-5293

Dorothea Bowlby, Director

A Specialized Employment Service for Medical and Hospital Personnel. (Men and Women.) For Administrators, Personnel Directors, Business Managers, Dietitians, Physicians, Directors of Nurses, Therapists, Pharmacists, Medical Record Librarians, Anesthetists, Public Relations Directors, Housekeepers, Bacteriologists, Biochemists, Medical Technologists, X-Ray Technicians, Food Service Managers. All inquiries from applicants are kept strictly confidential.

Information about

QUALIFIED NURSE PERSONNEL

is available from the

American Nurses' Association

PROFESSIONAL COUNSELING & PLACEMENT SERVICE

37 So. Wabash Ave.

Chicago 3, Ill.

STate 2-8883

(Continued on page 170)

FOR SALE

NURSING AND MEDICAL BOOKS

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS

400 East 59th Street, New York City

Does your Ethyl Alcohol supplier offer your Pharmacy all these advantages?

Dependable service from U.S.I.'s nationwide chain of bonded warehouses eliminates the need for excessive alcohol stocks, solves inventory and storage problems, is your most reliable source in case of emergency

The first requirement the pharmacist would set for ethyl alcohol is *purity*. But once the U.S.P. requirement is met (or exceeded, as it is with U.S.I. alcohol) he would add another qualification: *Service*.

Dependable delivery from a nearby source means the pharmacist doesn't have to keep excessive stocks on hand as a precaution against delayed deliveries. This in turn simplifies his inventory control records. His storage problems are minimized, yet he knows that the once-in-a-million call for emergency supplies of alcohol will be answered . . . immediately.

U.S.I. offers that kind of service. America's oldest producer of hospital and industrial alcohol, U.S.I. has nine bonded warehouses across the country. Its sales organization has been serving hospitals for half a century.

For your pure alcohol needs, specify U.S.I.—get purity *and* service.

U.S.I. INDUSTRIAL CHEMICALS CO.
Division of National Distillers and Chemical Corporation
99 Park Avenue, New York 16, N. Y.
Branches in principal cities

U.S.I. pure alcohol U.S.P.

classified advertising

SCHOOLS—SPECIAL INSTRUCTION

The BOSTON LYING-IN HOSPITAL offers to qualified registered nurses a six-months internship in maternity nursing. Clinical experience is offered in all phases. This includes antepartal clinics, delivery room, postpartum and diabetic unit, normal newborn, and premature nursery. Each nurse intern will have the opportunity to deliver a mother under supervision. An elective period will be spent in advanced experience in the area of choice. Room, laundry, food allowance and a stipend of $75 per month is granted. Rooms are provided in a graduated house. The registration fee is $20. For complete information write to Carolyn Davies, R.N., Director of Nurses, Boston Lying-in Hospital, Boston, Massachusetts.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all technique in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write, School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

RESULTS MAKE IT A WORTHWHILE INVESTMENT

There's one reason above all others that explains why The MODERN HOSPITAL is *the* choice of those using classified advertising to reach the hospital field. That reason is—RESULTS.

Whether you are looking for someone to fill a key position on your hospital team—or seeking a position personally—you will find the classified advertising pages of The MODERN HOSPITAL will give you the results you want.

Excellently qualified applicants are searching for new and better positions in hospitals every day. They can only serve you if they know of the opportunities you have available. By bringing you more qualified applicants, The MODERN HOSPITAL offers you the best possibilities of securing the ideal persons to fill your vacancies.

If you are planning a new hospital or expanding an existing one, you will find the classified pages of The MODERN HOSPITAL a practical solution in solving your needs for additional personnel.

Your classified advertisement in The MODERN HOSPITAL reaches 14,278 fully paid, voluntary subscribers.

The MODERN HOSPITAL is *the* way to obtain positions and people in the hospital field. Thirty years of leadership in classified advertising prove this.

The cost of an advertisement under "Positions Open" or "Positions Wanted" is just 20¢ a word ($4 minimum). For Schools and other types of advertising write for special rate — Classified Advertising Department, **The Modern Hospital Publishing Co., Inc., 919 N. Michigan Ave., Chicago 11, Illinois.**

Millard Fillmore Hospital, Buffalo, N.Y.

When you sound-condition, do it handsomely— with Gold Bond Travacoustic

Small wonder Nurse Carol Gustenberg looks pleased. That's Gold Bond® Travacoustic on the ceiling. Travacoustic is the beautiful, fissured mineral tile that absorbs up to 80% of all noises striking it.

Hospital patients, too, like Travacoustic. Not only does it provide the restful quiet so vital in convalescence, but it's easy on the eyes as well. And who sees more of the ceiling than a hospital patient!

Travacoustic® is fireproof... the mineral fibers *can't* burn. And the clean, white surface provides high, glare-free light-reflection. Easily vacuum-cleaned or repainted. For more information, write Dept. MH-28, National Gypsum Company, Buffalo 2, N. Y.

Gold Bond
BUILDING PRODUCTS

NATIONAL GYPSUM COMPANY

problem: **How to protect the fresh surgical wound when early hydrotherapy is indicated.**

solution: **Dress with Aeroplast.®**

The plastic film formed by Aeroplast spray-on surgical dressing cannot be dissolved by water. Aeroplast dressing allows the patient the full benefits of hydrotherapy without maceration and consequent retardation of wound healing. Few redressings are needed. Healing progress is easily observed through the transparent film.

Aeroplast plastic surgical dressing is a versatile instrument which the imaginative surgeon can use to solve other difficult or unusual dressing problems.

For successful use of Aeroplast, the aerosol container should be held at least 10 or 12 inches away from the area to be dressed. Then spray it on lightly —*just a swish over the wound*—and let it dry for 30 seconds. Apply two more times, still allowing sufficient time for drying and still at a distance of 10 or 12 inches. Don't expect to see a heavy, thick film. Three, light quick sprays form a film which, although transparent and barely visible, is an efficient surgical dressing and bacterial barrier.

If hemostasis is incomplete, a single layer of gauze may be placed along the incision while the first spray of Aeroplast is still sticky. Then continue technic as above.

Use of Aeroplast in both operative and traumatic surgery has been widely documented. May we send you reprints and literature?

AEROPLAST CORPORATION, 420 DELLROSE AVENUE, DAYTON 3, OHIO

®AEROPLAST — *plastic surgical dressing*
BRAND OF VIDESATE

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 200. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Gas Sterilization in Cry-O-Therm Unit

More than eight years of intensive research and development have gone into

the production of the new Cry-O-Therm for gas sterilization. It is designed for rapid and effective sterilization of heat or moisture and laboratory supplies. It uses a special 11 per cent ethylene oxide mixture known as Cry-Oxcide which is packaged in low pressure, disposable aerosol containers. One or two cans are used for each load, depending upon the length of the cycle desired.

The extreme permeability of Cry-Oxcide permits protective wrapping or prepackaging of instruments and supplies to be sterilized. Muslin or paper wraps can be used for items for immediate hospital use, while polyethylene film may be employed for packaging items for prolonged periods of storage, giving almost indefinite protection. Operation of the Cry-O-Therm is wholly automatic, except for loading and unloading. The chamber is 16 by 16 by 30 inches in size. **American Sterilizer Co., Erie, Pa.**

For more details circle #618 on mailing card.

Portable Room Conditioner Heats and Cools

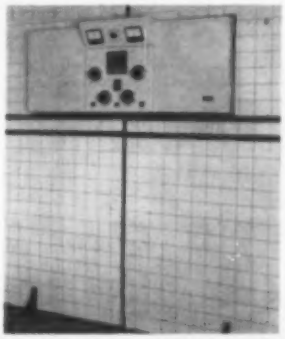
A new multi-use portable room air conditioner is introduced by Carrier. Weighing less than 60 pounds, the new unit heats as well as cools and can be used to remove dampness from a room if desired. For room cooling, the unit is mounted in the window and cools, dehumidifies, filters and circulates the air. A heat pump warms the room air when the unit is reversed. Identical grilles are used on each side of the dual-use conditioner. It is equipped with a handle for carrying from room to room and operates on standard electric current, drawing 7½ amperes. The aluminum cabinet has marproof vinyl plastic covering and is designed to withstand scuffing and abrasions. Slide-in extenders to fit the opening are placed in sturdy aluminum grooves on each side. **Carrier Corporation, Syracuse 1, N.Y.**

For more details circle #619 on mailing card.

"Type O.R." Control Unit for Hazardous Areas

An x-ray control panel is now available for use in and adjacent to the surgical suite and other hazardous areas of the hospital, and has Underwriters Laboratories approval when properly installed. The panel is designed for use with a newly developed x-ray tube and shockproof cables.

The "Type O.R." control panel is available for use with x-ray generators of any capacity from 200 MA to 500 MA. The new development, approved by Underwriters Laboratories for use in hazardous areas, thus permits radiographic work at high speeds in the operating room. It can be installed so that one, two or three tubes may be operated off a single machine.



Standard X-Ray Co., 1932 N. Burling St., Chicago 14.

For more details circle #620 on mailing card.

Intensifying Screens in Multi-Section Book

Du Pont "Patterson" intensifying screens for radiography are now available in a multi-section book. Designed for radiographic examination of different layers or depths of the body, the new multi-section book features seven pairs of "Patterson" intensifying screens spaced and matched in speed to produce uniformly exposed films for the seven levels. All screens in the book have identifying numbers which are recorded for the various body sections during the exposure. Multiple "cuts" of body sections can be produced with only a single exposure with the Polytomographic method. Radiation exposure of patient and personnel is thus reduced. **E. I. du Pont de Nemours & Co., Inc., Wilmington 98, Del.**

For more details circle #621 on mailing card.

(Continued on page 176)

High Output and Compactness in Cat D375 Electric Set

Either the new self-regulated constant voltage Cat Generator or an optional two-bearing generator is available on the new Cat D375 Spark-Ignition Electric Set. Combining high output with compactness, the new set is powered by the V-type, D375 Diesel Engine equipped with simple alterations for fuel carburetion and magneto ignition system for operating on methane, butane, propane or field gases.

The new set is available with either of two engine compression ratios and may be easily converted for diesel operation. A top-mounted exciter and a single, heavy-duty bearing make the unit compact. The self-regulated, constant voltage generator produces 60-cycle three-phase current with a choice of voltage. Easy operation and maintenance are assured as there are no moving parts. **Caterpillar Tractor Co., Peoria, Ill.**

For more details circle #622 on mailing card.

Sterile, Disposable Unit for Artificial Kidney

A newly-developed coil unit is now available for use with the artificial kidney. The unit is disposable, thus eliminating the possibility of cross infection and the expensive and time-consuming problem of clean-up. The new coil-type artificial kidney comes sterile, ready for immediate use, facilitating preparation and operation, and is low in initial cost. The artificial kidney consists of the dialyzing fluid pump, sigma-motor pump and temperature control units. The disposable dialyzing unit is being inserted into its holder in the illustration.

The artificial kidney is used to remove soluble waste products from the blood of patients who have accidentally or deliberately taken over doses of drugs and those

whose kidneys fail to work properly because of injury or disease. **Travenol Laboratories, Inc., Morton Grove, Ill.**

For more details circle #623 on mailing card.

WHAT'S NEW

Dip-and-Read Test for Ketonuria

Ketostix is a new simplified test for ketonuria. It consists of a paper strip, coated on one end with the reagents required for reactivity with ketone bodies. The test is performed by dipping the strip in a urine sample and comparing to a color chart on the bottle label. A color change on the strip indicates the presence of ketones. Ketostix was tested on large numbers of healthy subjects and patients, with no false reactions reported. It is supplied in bottles of 90 reagent strips. **Ames Company, Inc., Elkhart, Ind.**

For more details circle #624 on mailing card.

Hot-Pak Tray Servers Keep Tray Meals Hot

Designed to keep freshly cooked hot entrees hot for over one hour when used with any china dinner plate up to nine and one-half inches in diameter, the new Mealpack Hot-Pak Tray Server consists of three basic elements: tray, dome cover and heat battery. It is a simple, foolproof, durable unit. Tray Servers are effectively used with Mealpack compartmented china dishes, available in plain white or decorated, and with the Mealpack Pyrex type dish which is available with or without compartments.

The new Hot-Pak Tray Servers can be used with any traycart handling tray sizes of 16½ by 22½ inches with an overall filled tray height of five inches. They provide vacuum sealed protection for hot foods from main kitchens or floor pantries to serving points, keeping food hot on delayed trays. Shock and heat-resistant tough plastic is used in forming the tray and dome cover, and the heat battery is of Pyrex type glass which can be preheated in the oven or in a Mealpack Infra-Red Dish Heater. **Mealpack Corporation, 2014 Ridge Ave., Evanston, Ill.**

For more details circle #625 on mailing card.

Carlyle Quarry Tile Avaliable with Waxed Surface

The Mosaic line of Carlyle Quarry Tile is now available with a factory-applied waxed surface. The new surface facilitates clean-up after a tile installation as the wax prevents grout from adhering to the exposed surface of the tile and that which remains can be quickly removed. It is especially recommended for impregnated abrasive surface quarry tile and can also be ordered on any other six by six-inch Carlyle Quarry Tile. **The Mosaic Tile Company, Zanesville, Ohio.**

For more details circle #626 on mailing card.

(Continued on page 178)

Packaging papers for Johnson & Johnson guaranteed sterile hospital dressings undergo a battery of exacting physical and biological tests.

One test, the recontamination chamber (above), bombards paper samples with bacteria-sized particles to measure porosity.

guaranteed sterile Patient-Ready dressings

ACHIEVED through research
PACKAGED by modern equipment
STERILIZED with advanced techniques
MAINTAINED by continuous testing

Johnson & Johnson

PRE-WRAPPED, STERILE, PATIENT-READY

TOPPER® SPONGES

A highly absorbent sponge composed of a filmation of downy-soft cotton and cellulose enclosed in gauze.

THE MOST TRUSTED NAME IN STERILE SURGICAL DRESSINGS

Johnson & Johnson

WHAT'S NEW

Aeroplast Surgical Dressing in Two Additional Sizes

The new Aeroplast Plastic Protective Surgical Dressing with the light yellow tint to control application by defining the area being dressed, is now available in new three-ounce and twelve-ounce sizes. The three-ounce dispensing spray container is particularly adaptable for use on surgical dressing carts and in treatment rooms, while the new large twelve-ounce size is economical for operating room use following major surgery. The original clear Aeroplast spray dressing is still available in the six-ounce container. **Aeroplast Corporation, 420 Dellrose Ave., Dayton 3, Ohio.**

For more details circle #627 on mailing card.

Four Additional Sizes in Vinyl Tubing Line

B-D medical grade vinyl tubing can be sterilized by autoclaving, yet its low cost makes it disposable. Made of a new nontoxic vinyl compound formulated to provide a high degree of flexibility and clarity, the tubing is now available in four new sizes ranging in inside diameter from 5/16 inch to 0.120 inch. Larger-diameter tubings are designed for general purpose

irrigation and suction while the smaller diameter are primarily designed for intravenous therapy. The disposable tubing is supplied in handy spools to be cut to any desired length. Both ends of the tubing are heat sealed for cleanliness prior to use, and a dust plug is provided with each package to fit over newly cut ends. **Becton, Dickinson & Co., Rutherford, N.J.**

For more details circle #628 on mailing card.

No Messy Scrubbing With Kewanee Pot Washer

The Kewanee Pot and Pan Washing Unit is easy to use and cleans pots and pans without mess or scrubbing. A pumping action, combined with hot water and detergent, cleans the pans and keeps the water churned up so that no grease forms on top. Food particles removed from the pans are pulverized and soil is kept in suspension and drained out when the sink is emptied. The unit provides a "live water torrent" to sweep off the soil, yet it requires no plumbing connections and can be installed on any stainless or galvanized sink. **Kewanee Industrial Washer Corp., Kewanee, Ill.**

For more details circle #629 on mailing card.

(Continued on page 180)

WHAT'S NEW

Engineering Improvements in Streamlined Showerheads

Five new models are included in the Kohler line of showerheads. Engineering improvements assure long, trouble-free operation, and the streamlined design gives a modern, attractive appearance to shower rooms. The showerheads are engineered for sturdiness and immunity from vandalism as well as efficiency in operation.

A Kohler feature on each unit is the heavy phosphor bronze spring which maintains a constant self-adjusting pressure fit between the ball joint and the packing to prevent loose ball joints and leakage due to erosion of the packing. All new models are of all-brass construction with chrome finish. Two units have two-inch diameter heavy duty nylon shower faces for resistance to corrosion, liming and ordinary wear. One unit is self-draining, the other is manual draining, but both are vandal-proof. The other units include a small, light multi-spray, a compact self-cleaning nozzle type and a wide spray. **Kohler Co., Kohler, Wis.**

For more details circle #630 on mailing card.

Anesthetist's Chair Adjustable for Any Size

The Model A-2230 Ajustrite Anesthetist's Chair is instantly adjusted for comfortable seating for the anesthetist or anesthesiologist, regardless of height or size. Built to relieve strain and give proper support for comfortable posture, the chair is completely conductive and designed to meet operating room requirements in upholstery, frame and casters. Seat height is instantly adjustable without the use of tools. The seat is merely lifted to the desired height where it stays firmly until released. The seat adjusts from a low of 26 inches to a high of 34 inches.

Satin finish chrome plated 16-gauge steel tubing is used for the base of the chair and the footring. The seat has a two-inch foam rubber cushion 15 inches wide and 14½ inches deep. Conductive upholstery

is used to cover the seat and backrest cushions. **Ajusto Equipment Co., 515 Conneaut St., Bowling Green, Ohio.**

For more details circle #631 on mailing card.

Aluminum Asphalt Coatings Formulated in Colors

A complete line of aluminum paints and aluminum asphalt roof coatings is now available in colors which make them desirable for decorating as well as for protection and waterproofing. A special new aluminum pigment is the basis of the new formulations developed by Alcoa. The new metallic protective finishes are said to waterproof, insulate, decorate and preserve practically any type roof or metal surface.

The new colored asphalt product is suitable for use on vertical walls of cement, concrete, stucco and cinder block. It is easily applied with a brush, squeegee or spray gun. Since Alcoa does not make aluminum paints or roof coatings, the newly developed formulations are being made available to manufacturers of these products. **Aluminum Company of America, 721 Alcoa Bldg., Pittsburgh 19, Pa.**

For more details circle #632 on mailing card.

(Continued on page 182)

It's easy to have beautiful floors... and still shave maintenance costs!

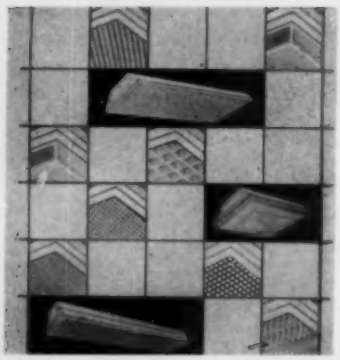
Here's how it's done . . . Clean floors with FLOATS-OFF, the concentrated synthetic detergent—its special cleaning booster makes dirt vanish in record time. Then, rinse. Let floor dry and apply WATER-PROOF WAX—it cuts waxing costs in half! Keep floor clean, dusted and polished (all at one time) with Holcomb's DUSTLESS SWEEPER.

With this three-step program we guarantee you'll find that floor care costs are the lowest possible . . . beauty the greatest . . . protection the longest lasting . . . maintenance the easiest.

Prove it on your own floors! Ask your Holcombman about the Introductory Floor Maintenance Package—a combination kit of four key floor care items that give beautiful floors at the lowest possible cost. And it's yours at a special introductory offer.

HOLCOMB SCIENTIFIC CLEANING MATERIALS

J. I. HOLCOMB MFG. CO., INC. · 1601 BARTH AVENUE · INDIANAPOLIS, INDIANA
Hackensack · Dallas · Los Angeles · Toronto



Lay-in Type Troffers for Lighting Versatility

The new Miller Versaline-Grid recessed troffer line is designed especially for use in exposed "T" furring and Acousti-Line ceilings. The versatility of size, closure and lighting level makes the line suited to a wide variety of lighting, structural and esthetic requirements. Units most suitable for the particular requirements can be selected from the matched line. The new troffers are shallow and can be quickly installed in plenums only eight inches deep. Installation is quick and easy and fixtures can be moved to conform to partition changes. **The Miller Co., Meriden, Conn.**

For more details circle #633 on mailing card.

Saratoga Model Is Multi-Purpose Whirlpool Bath

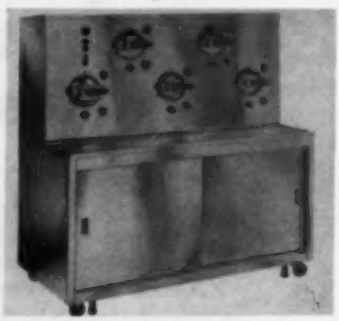
Capable of treating leg, arm, body or hip, the new Saratoga Model Whirlpool Local Bath is a multi-purpose unit. An electric turbine aerator provides the hydro-

massage produced by the new bath. The tub is elliptical in shape and has a closed roll-top edge for ease of cleaning and to facilitate complete sanitation. Three-inch electrically-conductive ball bearing rubber casters permit easy mobility of the Saratoga Model to any location in the hospital. The bath is 36 inches high, with a major axis of 36 inches and a minor axis of 14 inches. A stainless steel seat is supplied for hooking over the tub for hydromassage of the body. **S. Blickman, Inc., Weehawken, N.J.**

For more details circle #634 on mailing card.

Five-Compartment Model in Flex-Seal Speed Cooker

A new five-compartment model is now available in the Flex-Seal Speed Cooker. Made entirely of stainless steel, the new model will prepare from 720 to 900 servings of vegetables or other foods per hour, cooked in small quantities for freshness



in serving. Portion planning is thus possible and waste, labor and control costs are cut.

The Model #500 cooker is designed for direct steam connection while the Model #550 has its own steam generator. The full cabinet models have sliding doors in the base and are 60 inches wide, 31 inches deep and 62 inches high. Designed to cook with "dry" steam without adding water, each compartment of the Flex-Seal will cook an institutional package of frozen vegetables without defrosting in four to five minutes. **Vischer Products Co., 2815 W. Roscoe St., Chicago 18.**

For more details circle #635 on mailing card.

(Continued on page 186)

ONLY *National* Adding Machines have *Live Keyboard** . . . plus 13 other vital Owner-Operator features!

Never before have so many time-and-effort-saving features been placed on one adding machine. Compare them—feature by feature—with any other adding machine:

1. "Live" keyboard.
2. Instantly adjustable keytouch.
3. Automatic clear signal.
4. Subtractions print in red.
5. Automatic credit balance prints in red.
6. Automatic space-up of tape when total prints.
7. Large answer dials.
8. Easy-touch key action.
9. Full visible keyboard.
10. Automatic ciphers.
11. Rugged duty construction.
12. Keyboard interlock.
13. Four-way paper space control.
14. Three-way repeat. (quietness and beauty, too!)

Reduce hand-motion and effort up to 50% with National's exclusive "Live" keyboard, instantly adjustable to any operator's touch. *Every* key operates the motor—so you can *forget the motor bar.* No more back-and-forth motion from keys to motor bar.

A National "De luxe" Adding Machine pays for itself with the time-and-effort it saves, continues savings as yearly profit. One hour a day saved with this National will, in the average office, repay 100% a year on the investment. See a demonstration on your own work. Call nearest National branch office or dealer. See phone book yellow pages.

"TRADE MARK REG. U. S. PAT. OFF."

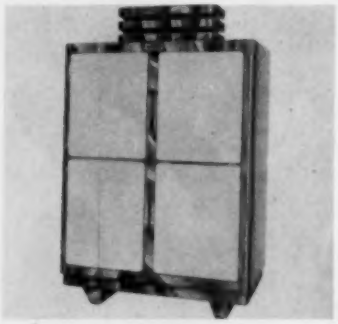
National

ADDING MACHINES • CASH REGISTERS
ACCOUNTING MACHINES
NCR PAPER (NO CARBON REQUIRED)

THE NATIONAL CASH REGISTER COMPANY, DAYTON 9, OHIO
989 OFFICES IN 94 COUNTRIES

WHAT'S NEW

Condensed Cabinet in Koch Reach-in Refrigerators



The new Koch Series "MA" line of Reach-in Refrigerators incorporates the features of the Series "M" Refrigerators in a new condensed cabinet 26 inches deep. Available in four-door and six-door models, the new units have net capacities of 32 and 50 cubic feet.

Extreme flexibility of arrangement with completely adjustable, removable and interchangeable interiors makes the units adaptable for all uses. Of all welded steel construction, the new line is available with solid or glass doors. Interiors are practically seamless and coved for easy corner cleaning. All hardware is flush with door surfaces. The new refrigerators are available in stainless steel. **Koch Refrigerators, Inc., 401 Funston Rd., Kansas City 15, Kans.**

For more details circle #847 on mailing card.

Movable Wall System Is All-Aluminum

The new Hauserman modular movable aluminum wall system was jointly developed by the E. F. Hauserman Company and the Reynolds Metals Company. The wide variety of precision components available in the system can be integrated in a number of combinations for any need. All components are based on a four-inch module throughout. Natural aluminum or an almost unlimited number of colors can be used in the wall panels of the system. Also available are embossed panels in a variety of textures and patterns, in natural metal or in color.

Recessed base and ceiling trim assure a clean, modern appearance for the completed installation. The trim is removable for access to utility wiring from both sides of the partition. **E. F. Hauserman Co., 2100 Keith Bldg., Cleveland 15, Ohio.**

For more details circle #848 on mailing card.

Beverage Cooler Employs Forced Air System

The new Quikold electric beverage cooler operates with a forced air system which produces fast, economical cooling. The Model 2100-FA cooler has four cooler dividers to provide divided storage space and will hold 19 cases of 7-ounce bottles, 16 cases of 8-ounce bottles or 12 cases of 12-ounce bottles. The unit is designed for dry operation only and measures 64½ by 26 by 35 inches. **S & S Products, Inc., P.O. Box 1047, Lima, Ohio.**

For more details circle #849 on mailing card.

(Continued on page 186)

Versatilt Venetian Blind Operates in Two Sections

Distractions from outside can be cut out and privacy obtained without shutting out light and air with the new development in venetian blinds known as Versatilt. Versatilt features dual control for the upper and lower sections of the blind, permitting the bottom section to be closed while the upper section is open to admit light and air. Each section adjusts smoothly, with one cord, to any position within an arc of 180 degrees. The new single-cord control action is also available in a single-section venetian blind called Unicord.

With Versatilt, blinds can be adjusted to suit any need. Either section may be open, half-open, half-closed or closed, independent of the other section of the blind.

The completely enclosed control mechanism is ruggedly constructed for years of trouble-free service and the entire head-rail unit is dustproof. **C. B. White Co., Inc., Auburndale 66, Mass.**

For more details circle #850 on mailing card.

Comfort and Efficiency in Oxygen Therapy Mask

The Non-Rebreathing Type Ohio 100 Oxygen Therapy Mask has been improved for added patient comfort and effective operation. A special, new Oxygen Diluter ensures patients receiving the prescribed amount of oxygen in the needed volume of air for ventilation. The new unit permits adjustments of desired mixtures of pure oxygen and air from 40 to 95 degrees oxygen. The flow can be adjusted or changed without affecting the concentration, once the concentration has been set.

Soft latex rubber is used for the face piece of the new Ohio 100 Mask for added patient comfort. It is styled to conform to the contour of the patient's face, without contact pressure points. Resistance through the exhalation valve to the patient's expired breath is negligible. The new mask can be quickly converted for aerosol therapy when desired. **Ohio Chemical and Surgical Equipment Co., Madison 10, Wis.**

For more details circle #636 on mailing card.

"Humidity Room" Provided With Humidifier

The new Walton Model HA Hospital Humidifier can make any bed a "humidity room." The humidity canopy envelopes the entire bed for either children or adults, and the humidifier permits humidity of any desired percentage from 60 to 100. The desired amount of humidity in the vapor entering the canopy is regulated by the vapor output control. The specially designed bed-sized canopy allows the patient freedom of movement. The Walton Model HA can also be used for introducing moisture into any oxygen canopy. **Walton Laboratories, Inc., 1186 Grove St., Irvington 11, N.J.**

For more details circle #637 on mailing card.

Mortuary Shroud Garment of Disposable Creped Paper

A strong white opaque creped paper is used in the new Busse disposable mortuary shroud garment which has an attached hood. Created to replace more expensive muslin sheets, the new mortuary shroud garment is formed for the purpose with the face-covering hood. It is priced for disposability. **Busse Hospital Products, 64 E. 8th St., New York 3.**

For more details circle #638 on mailing card.

Kard-Up Filing System Combines Vertical and Visible

The new Kard-Up filing system employs the specially designed Kard-Up folders, permitting the use of the visible signal system of Kardex with a vertical card file. It is available in six by four card size, punched-card size and eight by five card size. A transparent Transoloid plastic strip across the top of the Kard-Up folder, with die-cut flaps at the base, permits the title card to be elevated above other cards in the folder. Transparent signals provide visible signalling, with all related records in the folder. The system accommodates nearly all types of records and has other features for versatile and efficient operation. **Remington Rand Division of Sperry Rand Corp., 315 Fourth Ave., New York 10.**

For more details circle #639 on mailing card.

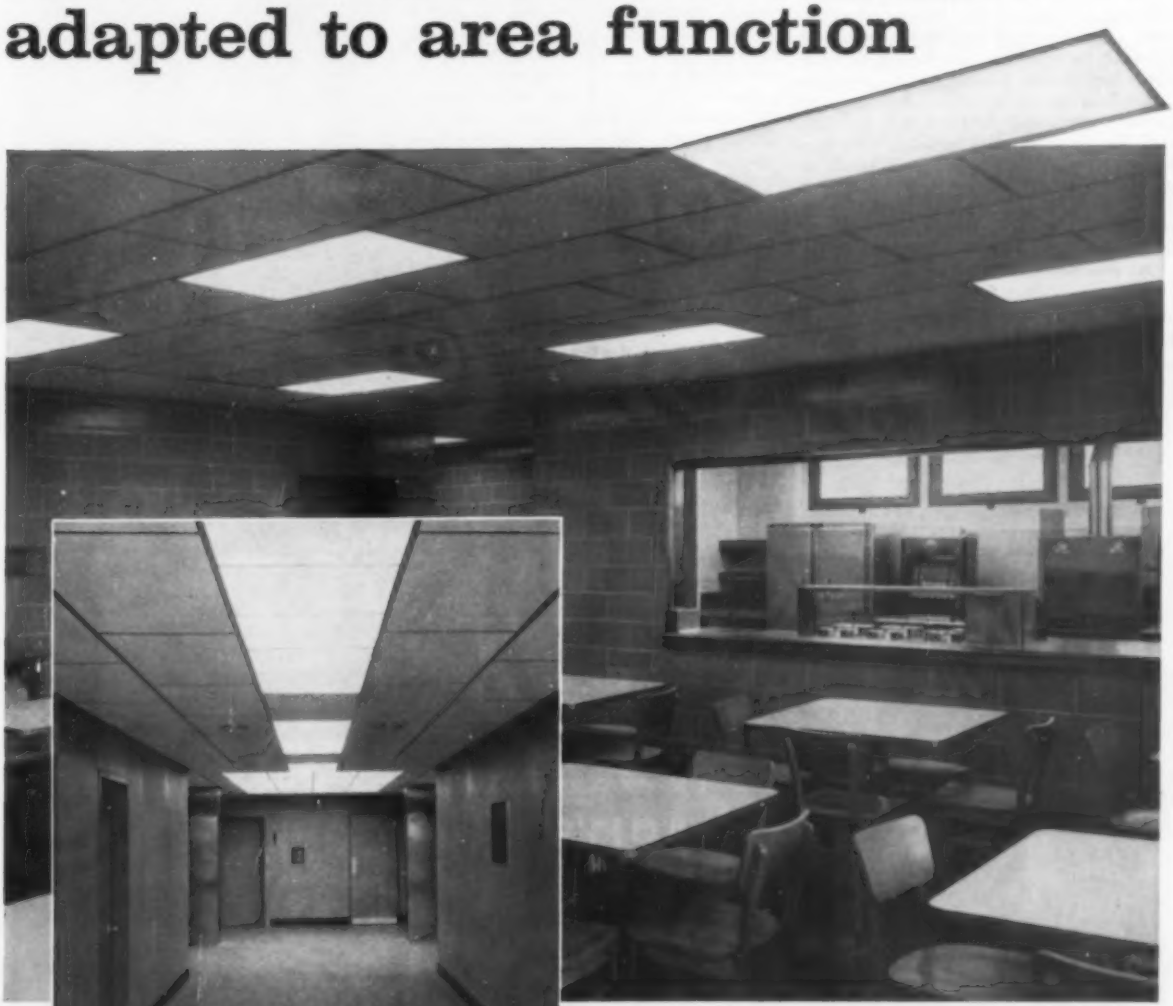
Automatic Gas Water Heater Has Copper-Nickel Alloy Tank

The Copper Nickel Sanimaster is a new automatic gas water heater for institutional use. The copper-nickel alloy tank is engineered to provide rust-free hot water and assure long appliance life. The Model CST 80-80, designed for use with natural, mixed, manufactured and LP gases, can be installed singly or in multiples for single or two-temperature operation. It is approved by the AGA Laboratories as an automatic storage water heater and as a circulating tank water heater. **Ruud Mfg. Co., Kalamazoo, Mich.**

For more details circle #640 on mailing card.

(Continued on page 188)

New DAY-BRITE Mobilex®... adapted to area function



MOBILEX creates a cheery atmosphere in the dining room of the Continued Treatment Building at Norwich Hospital, Norwich, Conn. Walter P. Crabtree, Jr., *Architect*. Howard W. Harper, *Electrical Engineer*. Ealahan Electric Co., *Electrical Contractor*.

MOBILEX provides a high level of illumination for this corridor.

Here's *decidedly better* Day-Brite design in a lighting fixture that's ideal for modern hospitals. It takes full advantage of the economies offered by modular construction.

Get the whole story on Mobilex versatility. Write for your copy of "MODULAR LIGHTING", or call your Day-Brite representative listed in the Yellow Pages.

DECIDEDLY BETTER
DAY-BRITE
Lighting Fixtures

Z-88

Day-Brite Lighting, Inc., 6280 N. Broadway, St. Louis 15, Missouri
Day-Brite Lighting, Inc., of Calif., 530 Martin Ave., Santa Clara, Calif.

NATION'S LARGEST MANUFACTURER OF COMMERCIAL AND INDUSTRIAL LIGHTING EQUIPMENT

WHAT'S NEW

Dextol Saves Time in Tolerance Tests

S/P Dextol is a pleasantly flavored ready-mixed product for glucose tolerance tests. There is no weighing, mixing or flavoring to be done, thus saving time of technologists and patients. The pleasant lemon-lime flavor removes objections of patients, yet S/P Dextol is highly accurate and compatible with standard glucose tolerance procedures. It is bottled in graduated containers for easy calculation of dosage in methods involving body weight. **Scientific Products, Division American Hospital Supply Corp., Evanston, Ill.**

For more details circle #641 on mailing card.

Electric Food Warmer Available in Five Models

Years of engineering research devoted to the operating characteristics of all kinds of food warmers resulted in the development of the new Vapormatic. The new electric food warmer is available in five models, ranging from two feet six inches to six feet in length. It is an automatic moist heat food warmer which is extremely economical to operate. It is constructed to prevent overheating, drying out and steam, and operates on water vapor below the boiling point. The exclusive Dial-a-Food controls are adjusted for the particular food in each compartment and a constant supply of moist heat is automatically provided at just the right temperature without manual filling. **The Bastian-Blessing Co., 4203 W. Peterson Ave., Chicago 30.**

For more details circle #642 on mailing card.

Drop-In Waste Receptacles Resist Corrosion

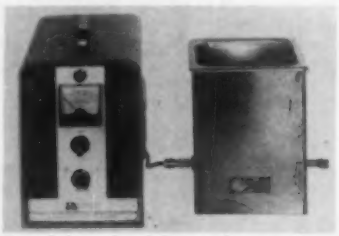
Double corrosion resistance is provided by the chrome plated finish and the phosphate treatment over the chemically cleaned heavy gauge steel in the new Bennett line of closed drop-in waste receptacles. Neatness and cleanliness are made possible by the self-closing overlapping top door which also lessens chance of fire inside due to the lack of air.

The round design of the new model makes a pleasing appearance in all surroundings. A water-tight, rust-proof liner which is easy to remove is included with every model. The waste receptacle is also available in a variety of colors. **The Bennett Mfg. Co., Alden, N.Y.**

For more details circle #643 on mailing card.

(Continued on page 190)

Ultrasonic Cleaning Unit Is Portable and Durable



Portability, durability and ease of maintenance are features claimed for the new Acoustica Model DR 50-AH Ultrasonic Cleaning Unit. The low-priced unit offers a second tank for alternate operation which is controlled by the built-in tank selector. Consisting of a compact generator and the transducerized tank, the new model has an outlet tap for hookup with external recirculating filter or temperature control system. It is light in weight and requires no special wiring or installation.

The heavy gauge stainless steel tank has rounded corners for easy cleaning and is nine inches high, 5¾ inches square, and has more than a half gallon cleaning capacity. The generator is ten inches high, seven inches wide and ten and one-half inches deep. The Model DR 50-AH is distributed exclusively in the hospital field by the Scientific Products Division of the American Hospital Supply Corporation, Evanston, Illinois. **Acoustica Associates, Inc., 26 Windsor Ave., Mineola, N.Y.**

For more details circle #644 on mailing card.

Hospital Casework by *St. Charles*

At McKennan Hospital, Sioux Falls, S. D.

Arch.: Harold Spitznagel & Assoc.

Hematology

Tissue Laboratory

Oral Surgery

General Laboratory

Functional beauty was the guiding concept in the construction of this new addition to McKennan Hospital, Sioux Falls, where skilled use of color interiors complement the clean architecture of the building. This concept was carried through even to the selection of St. Charles Steel Casework in color.

St. Charles' quality, dependability and ability to meet special requirements are fast making Casework by St. Charles synonymous with the best in hospital equipment. Perhaps our skilled personnel and modern construction facilities can serve you too. Inquires will receive prompt attention.

A request on your letterhead will bring our 40-page catalog, "St. Charles Hospital Casework."

StC

casework • sinks and counters • special purpose units

ST. CHARLES MANUFACTURING COMPANY, DEPT. MHH-2, ST. CHARLES, ILLINOIS

WHAT'S NEW

Duraco Vinyl Tile Is Especially Durable

Asbestos fiber, inert filler and coloring pigment are bound together by a 100 per cent vinyl binder to form the heavy duty line of Azrock Duraco durable vinyl tile. The result of years of intensive research and development, Duraco is greaseproof, easy to keep clean, and requires no waxing. It is designed primarily for use in areas with heavy traffic. Duraco is available in five marble and five terrazzo patterns in nine by nine-inch size, 3/32 and 1/8 inch thicknesses. **Azrock Products Div., Uvalde Rock Asphalt Co., Box 531, San Antonio, Texas.**

For more details circle #645 on mailing card.

Bedside Floor Lamp Has "Safety-Tip" Design

The "Safety-Tip" feature of the new Futura Hospital Bedside Floor Lamp permits the lamp to tip almost 35 degrees without falling. Another feature of the new lamp is the Scuff-Proof base which prevents scuffing from floor cleaners, since they slide under the base. The new Futura has seven different types of light in addition to a convenient electric outlet. The ventilated shade stays cool enough to prevent burns from contact, and the rolled bottom eliminates sharp edges.

The inside rotary reflector of the lamp can be turned for use as an examination light or to give additional light for reading and other patient needs. The stem turns easily in the base to direct the light away from the bed when desired. A special light permits a night nurse to see without disturbing the patient. Switches are at convenient mattress level. The new Futura is available in nine new decorator color combinations. The light is said to have Underwriters Laboratories approval. **Faries Lamp Division, Elwood, Ind.**

For more details circle #646 on mailing card.

Beautiflor Traffic Wax for Light-Colored Floors

Designed especially for use on light-colored floors of vinyl, linoleum and wood, Trans-Lite is a new formula for Beautiflor Traffic Wax. It pours white and dries light, deepens colors and does not yellow, even on white floors. Made of special waxes chosen to give extra protection to floors subjected to heavy traffic, the new formula makes maintenance easier as it is quick and easy to apply, dries fast and buffs easily. **S. C. Johnson & Son, Inc., Racine, Wis.**

For more details circle #647 on mailing card.

(Continued on page 192)

THERE IS NO OTHER

Comfort Conditioning so well adapted to Hospital Use!

The BURGESS-MANNING Radiant Acoustical Ceiling

Remember

Your Building is Better —

Your Building Budget No Bigger

The Only Completely Integrated Radiant Heating, Cooling and Acoustical Ceiling

A Burgess-Manning Radiant Acoustical Ceiling completely comfort conditions a building winter and summer and, in addition, provides the best possible acoustic control to absorb noise.

It not only performs these functions but performs them with superior efficiency and economy, with no additional first cost and an actual reduction in maintenance cost.

Radiant heat, Nature's own method, has long been recognized as the more technically correct method of any known means of heating for human comfort. It is particularly advantageous for hospital use. Since it is not dependent on air currents, unpleasant drafts are eliminated. Floors are always warmer than the air of the room—there is no appreciable difference in room temperature from floor to ceiling—concentrated heat sources or cold spots are eliminated. All of these advantages are particularly desirable in hospital buildings.

From a structural standpoint, the Burgess-Manning Ceiling provides more architectural design freedom, more useful floor area and building space. Because of its operational efficiency and the inherent advantages of radiant heat, fuel economies are obtained as well.

The Burgess-Manning Radiant Acoustical Ceiling might have been designed especially for hospital use.

Write for Burgess-Manning Catalog No. 138-2M

SEE OUR CATALOG IN SWEET'S ARCHITECTURAL FILE OR WRITE FOR COPY

3 Heating Cooling Acoustical

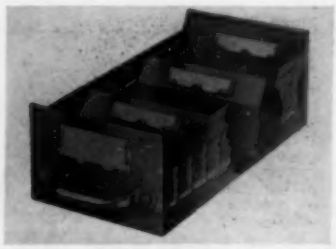
BURGESS-MANNING COMPANY

Architectural Products Division

5970 Northwest Highway, Chicago 31, Ill.

WHAT'S NEW

Locking Dividers for Steel File Drawers



New design details are incorporated into the Equipto line of steel file drawers. Notched cross dividers are engaged by embossed drawer sides which lock the dividers in place. Dividers cannot creep up and tiny parts are kept separated, yet dividers are removed easily when desired. The drawers also have embossed runners on the bottom for easy operation. **Equipto, Aurora, Ill.**

For more details circle #648 on mailing card.

Ultraviolet Lamp Provides Bacteria Barrier

Designed for insertion in heating and air conditioning ducts in institutions, the new Westinghouse Sterilamp G10T5-½ produces high radiation effective in killing bacteria, viruses and molds. The new ultraviolet lamp is highly efficient and tests indicate that 80 per cent of air borne virus and bacteria are destroyed when a single ultraviolet lamp is installed in a duct. As air is recirculated in the ducts, more bacteria are destroyed on exposure to the Sterilamp tube, reducing infection in the air to a minimum. **Westinghouse Electric Corp., Box 2278, Pittsburgh, Pa.**

For more details circle #649 on mailing card.

Door-Type Dishwasher Is Semi-Automatic Unit

A new single tank, semi-automatic, door-type dishwashing machine is introduced by Universal Dishwashing Machinery Company, a member of United Manufacturers. All interior parts, tracks, strainer pans, shelves and wash and rinse assembly are easily removed by hand for complete and thorough cleaning. The top cover, front panel and back cover are also easily removable. The new SR Regular Model can be installed for straight through or corner operation. It is equipped with three doors,

two of which operate simultaneously. Single lever operation is provided for wash and rinse which cannot be operated together.

The Model SR will handle racks 19¾ inches square and has a newly designed power wash and rinse that revolves above and below the dishes for thorough cleaning. **United Manufacturers, Inc., 50 Windsor Place, Nutley, N.J.**

For more details circle #650 on mailing card.

Medic-Alert Bracelets for Medical-Problem Patients

Identification of cases with medical problems which may result in emergencies is now possible with the new Medic-Alert bracelet. The sterling silver bracelet has a caduceus with the words "Medic-Alert" in red enamel on a flat plaque. On the reverse of the plaque the patient's particular handicap is engraved. Bracelets are available for diabetics, epileptics, persons with severe allergies to antibiotics, drugs, and other products, those taking digitalis, Dilantin and other medication, and for those who wish to have their blood types readily identified. Wearing of the bracelets by patients with medical problems is designed to protect them from incorrect treatment in case of emergency. **Medic-Alert Foundation, 1030 Sierra Drive, Turlock, Calif.**

For more details circle #651 on mailing card.

(Continued on page 194)

WHAT'S NEW

Self-Closing Lid for Refuse Containers

Any 55-gallon drum can be readily converted as a sanitary refuse or bulk storage container with the new "Big Top" self-closing drum lid. Both the cover and the inner hinged flap of the new lid are made of 22 gauge steel finished in gray enamel. The word "Push" is embossed in red letters on the flat opening. The lid has a king-sized opening, large enough to push in bulky items from any angle. The unique rain-slant design assures water run-off. **The Witt Cornice Co., 2121 Winchell Ave., Cincinnati 14, Ohio.**

For more details circle #652 on mailing card.

Pharmaceuticals

Isuprel-Franol

Isuprel-Franol is a dual-purpose tablet especially designed to provide fast relief of acute attacks of bronchial asthma, as well as daily prophylaxis in chronic conditions. The tablet has a three-layer construction, the central core of Franol which is an oral prophylactic for day-to-day management of bronchial asthma; a lemon "flavor-timer" between the sublingual layer and the central core, and an outer, sublingual layer of Isuprel for quick control of bronchospasm. The tablet is used sublingually until the lemon "flavor-timer" is reached, which is the signal for swallowing the balance of the tablet. For adults, the concentration of Isuprel in the combination tablet is 10 mg. For children, Isuprel-Franol Mild Tablets contain five mg. of Isuprel. **Winthrop Laboratories, 1450 Broadway, New York 18.**

For more details circle #653 on mailing card.

Filmtab Gerilets

Filmtab Gerilets is a geriatric supportive formula providing a full range of dietary and therapeutic support for older patients. Each tablet contains all the essential vitamins in sufficient quantities to augment a reduced dietary intake, iron, folic acid and vitamin B_{12} with intrinsic factor, ascorbic acid and Quertine for reducing increased capillary fragility, lipotropic factors, Desoxyn for a mild stimulant and Sulestrex and methyltestosterone for optimal hormonal balance. Gerilets are supplied in bottles of 25, 100 and 250 tablets. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #654 on mailing card.

Arcofac

Arcofac is a new liquid for control of high levels of cholesterol in the blood. Each tablespoonful contains as an emulsion, essential fatty acids derived from safflower oil and pyridoxine hydrochloride. The usual adult dosage is stated as one tablespoonful daily for patients suffering from atherosclerosis, heart conditions, diabetes and other conditions. Arcofac is supplied in 12-ounce bottles. **The Armour Laboratories, P.O. Box 511, Kankakee, Ill.**

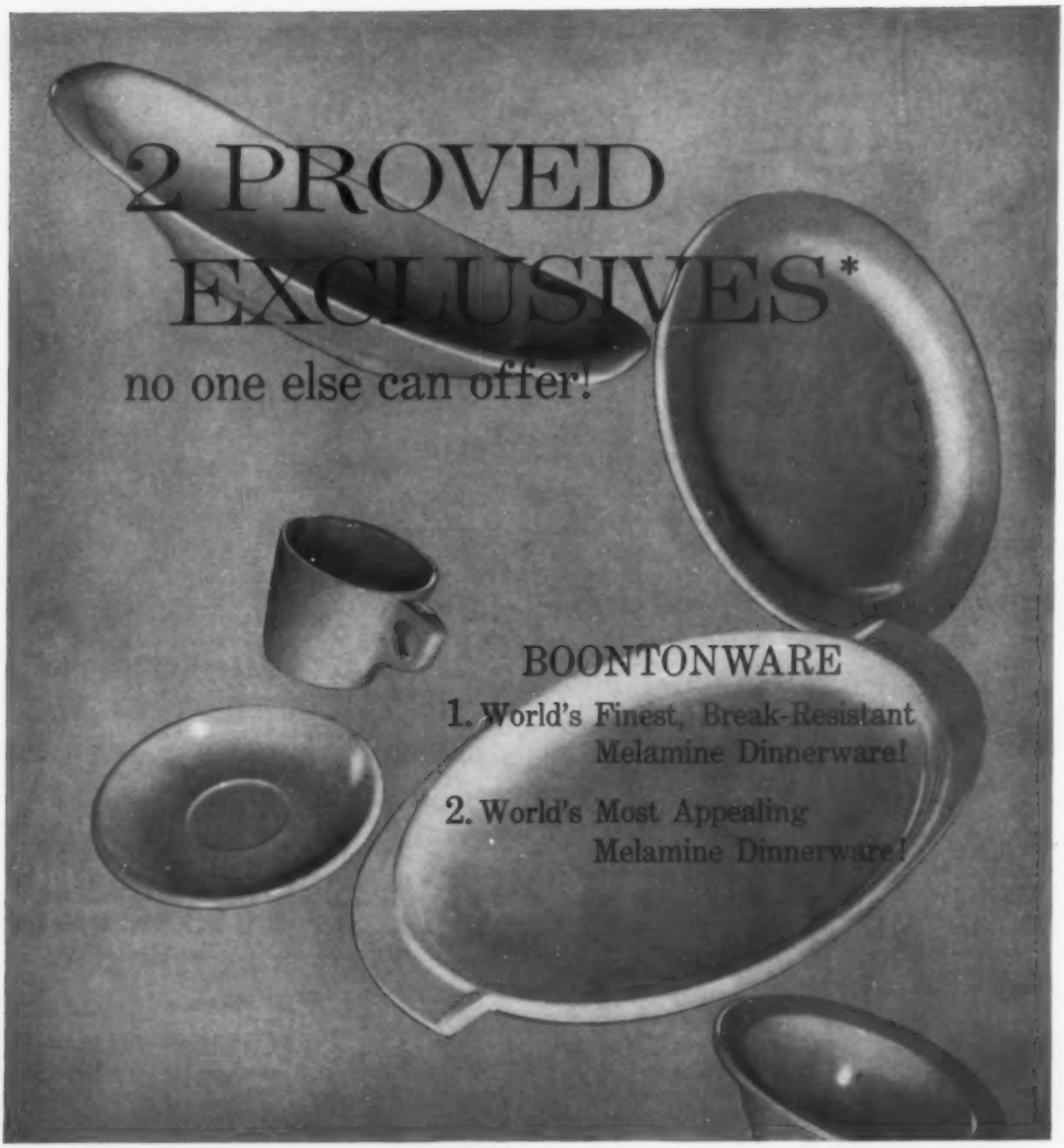
For more details circle #655 on mailing card.

Vesprin

Vesprin is a new phenothiazine derivative indicated in the treatment of various acute and chronic psychoses. It is described as efficient in modifying behavior, thus being particularly useful in the management of the psychomotor hyperactivity and overt hostility frequently associated with such conditions as schizophrenia, mania and psychoses due to brain disorders and senility, as well as in alcoholism and drug withdrawal. It is contraindicated in comatose states due to central nervous system depressants. Vesprin induces minimal side effects and possesses a relatively low order of toxicity. It is supplied for oral use as tablets containing 10, 25 and 50 mg. in bottles of 50 and 500, and as a solution for intramuscular injection for investigational use. **E. R. Squibb & Sons, 745 Fifth Ave., New York 22.**

For more details circle #656 on mailing card.

(Continued on page 196)



Plus everything everyone else offers

Stacks evenly, handles easily • Minimizes clatter • Machine-washes safely in hottest water • Much lighter than other dinnerware — a tray full weighs a trifle • Food stays hot or cold longer • Washes clean and wipes dry quicker, easier • Odor-free

*Boontonware's exclusives are not mere claims — but actual facts! Boontonware *is* finest and most appealing, as proved by its use by millions of homemakers. These millions bought and used Boontonware to make their home-dining more enjoyable. Let Boontonware enhance the dining pleasure of these same millions in your group-feeding operation, too. Don't settle for second-best — insist on famous Boontonware!

SIX COLORS TO MIX OR MATCH IN THREE STYLES

Butter Yellow	Powder Blue	Honeydew Green
Tawny Buff	Bon Bon Pink	Shell White

Boontonware far exceeds CS 173-50, the heavy-duty Melamine dinnerware specifications as developed by the trade and issued by U. S. Department of Commerce, and conforms with the simplified practice recommendations of the American Hospital Association.

Boontonware®

finest of all Melamine dinnerware

BOONTON MOLDING CO., BOONTON, N.J.

WHAT'S NEW

Literature and Services

• The new line of Kimax heat-resistant glassware is included in the newly revised manual, **"The Care and Handling of Glass Volumetric Apparatus,"** released by Kimble Glass Co., Toledo 1, Ohio. The 24-page booklet, designed for laboratory workers, technicians and students, gives valuable information and assistance in prolonging life and accuracy of glass measuring instruments. The manual, divided into four chapters, contains illustrations, tables and charts in addition to the text.

For more details circle #657 on mailing card.

• **"What Every Executive Should Know About This Vital One Thousandth of an Inch"** is the title of a 32-page booklet published by Masury-Young Co., Dept. MH, 76 Roland St., Boston 29. Presenting an individual maintenance plan for each type of floor, the booklet discusses how flooring materials affect maintenance, and how costs are reduced by effective maintenance, keeping floors looking better for longer periods with less attention.

For more details circle #658 on mailing card.

• The advantages offered by use of the open shelf filing unit known as Verti-File are discussed in a new brochure entitled **"If you have a space problem for files . . . you'll like this!"** Released by Deluxe Metal Furniture Co., Warren, Pa., the folder describes the savings in floor space and in equipment cost possible with Verti-File, a cabinet-type unit with several variations to meet particular needs.

For more details circle #659 on mailing card.

• **A comprehensive laundry planning service for hospitals** is now available to architects and administrators from The American Laundry Machinery Co., Cincinnati 12, Ohio. Finished plans are prepared by the company's survey engineers on receipt of basic information as to needs. Also available is the "Architect's Reference Guide" containing full information on the complete line of American Laundry equipment.

For more details circle #660 on mailing card.

• **Catalog #93A** gives factual information about hinge location, finishes, door frequency, bearings and the various types of hinges and their uses. Prepared by McKinney Mfg. Co., 1715 Liverpool St., Pittsburgh 33, Pa., the illustrated booklet also contains information on U. S. Government specifications.

For more details circle #661 on mailing card.

• The complete line of specialties and sundries for hospitals, laboratories and physicians handled by Graham-Field Surgical Co., Inc., Woodside 77, N.Y., is illustrated and described in **Catalog No. 9.** The new 144-page book is indexed alphabetically by product as well as by catalog number.

For more details circle #662 on mailing card.

• **"Food Service in The Modern Hospital"** is the subject of an illustrated brochure designed for administrators and other executives, architects and consultants, as well as heads of the dietary department. Published by Samuel Olson Mfg. Co., Inc., 2418 Bloomingdale Ave., Chicago 47, the new brochure explains in detail the concept of mechanized hospital food service. Diagrams, photographs and feeding schedules supplement the descriptive text.

For more details circle #663 on mailing card.

• How the five basic **Commercial Garbage Disposers** manufactured by Waste King Corp., 3300 E. 50th St., Los Angeles 58, Calif., can be adapted in 31 different ways to meet any need in mass feeding operations is described in a new pamphlet. The colorful fold-out pamphlet also includes a chart detailing the grind ring and turntable assemblies of the five units, and a description of how the Waste King Pulverator operates.

For more details circle #664 on mailing card.

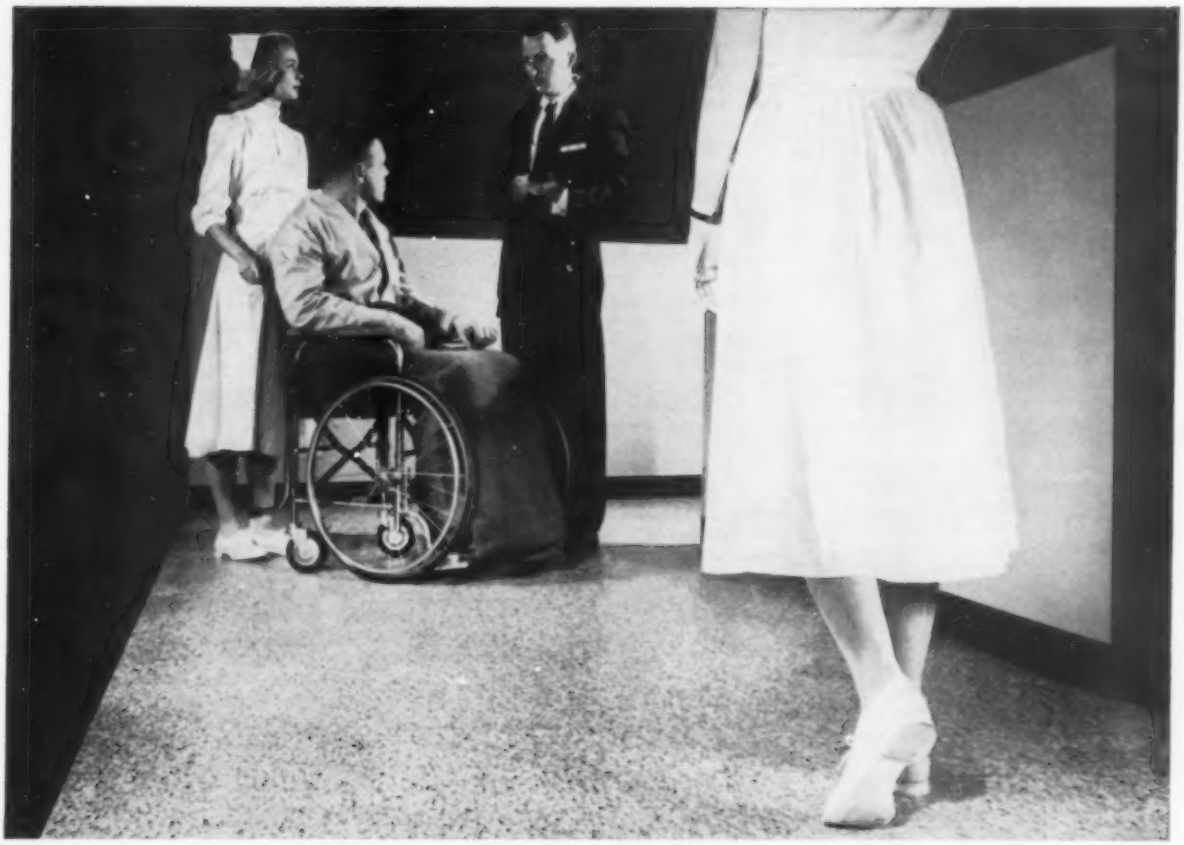
• How the Sola water treatment system operates, with general information on the subject of water treatment, is discussed in a 12-page brochure entitled **"Tips to Successful Maintenance"** issued by Sola Corporation, 2808 McKinney Ave., Dallas 1, Texas. The technical application of Sola is described with catalog data on parts of the system.

For more details circle #665 on mailing card.

• A new **"Engineering Data Sheet Service"** presents three solutions to the problem of providing electrical outlets for the many electric typewriters and business machines now in use. Available from The Wiremold Co., Hartford 10, Conn., **Data Sheet A-11** contains suggested layouts for office areas using 2000 Plugmold.

For more details circle #666 on mailing card.

(Continued on page 198)



Gold Seal® HAS THE RIGHT PRODUCT FOR EVERY HOSPITAL FLOOR NEED

1. **For corridors, sickrooms, wards and heavy traffic areas**—Gold Seal ⅛" Inlaid Linoleum, with colors clear through to the backing, assures years of wear even in areas of heaviest traffic. Durability proven by installations in constant use after more than 25 years. Available in classic Veltone® or exciting new Sequin® in a full color range. Easy-cleaning surfaces resist grease and grime, hide scuffs and scratches. 6′ widths provide virtually seamless floors, fewer germ-breeding cracks.

2. **For X-Ray and operating rooms**—Gold Seal Static-Conductive Linoleum, an exclusive Gold Seal product that prevents static electricity hazards. Tested and approved for danger areas in famous hospitals throughout the country. Meets the requirements of the Underwriters' Laboratories, Inc. and the National Fire Protection Association.

3. **For waiting and reception rooms**—Gold Seal Nairon* Custom Tile, the full-thick homogeneous vinyl plastic tile with built-in dimensional stability. Exceptionally resilient and comfortable, it withstands heaviest loads. Resists stains, dirt, and solvents. Available in ⅛" and .080" gauge. 49 colors.

4. **For "problem" floors**—Gold Seal Vinylbest* Tile, a versatile blend of vinyl and asbestos that literally can be installed anywhere—ideal for areas where seepage and moisture create problems.

5. **For noisy areas**—Gold Seal Rubber Tile, supreme in resilient, silent comfort. Long-wearing and resistant to indentation, yet so quiet and easy underfoot.

6. **For ground-level and basement floors**—Gold Seal Asphalt Tile, handsome and practical for basements and other areas where concrete flooring is in direct contact with the ground. This economical tile shrugs off alkalinity.

FOR HOME . . . BUSINESS . . . INSTITUTIONS:

BY THE YARD AND TILES — Inlaid Linoleum • Nairon® Plastics • Vinylbest* Tile
Cork Tile • Rubber Tile • Asphalt Tile
PRINTED FLOOR AND WALL COVERINGS — Forecast* Vinyl • Congoleum® and Congowall® • *Trademark

SATISFACTION GUARANTEED OR YOUR MONEY BACK

CONGOLEUM-NAIRN INC., KEARNY, N. J.

FOR THE LOOK THAT'S YEARS AHEAD

Gold Seal® FLOORS AND WALLS

*Trademark

WHAT'S NEW

• **"Hospital Cleaning With Spencer Vacuum"** is the subject of **Bulletin No. 157** issued by The Spencer Turbine Co., 486 New Park Ave., Hartford 6, Conn. The stationary vacuum cleaning and Mop-Vac systems are described, with data on how the system permits quick, thorough vacuum cleaning of dry mops, with other uses of the system, including boiler cleaning, water pick-up and cleaning of venetian blinds.

For more details circle #667 on mailing card.

• The activities of the Mallinckrodt Chemical Works, Second & Mallinckrodt Sts., St. Louis 7, Mo., in development of the first self-sustaining nuclear reaction, is described in a new booklet, **"First in War . . . First in Peace,"** recently released by that company. In words and pictures the dramatic story of the processing steps involved in turning crude uranium into useable fissionable fuel, and of Mallinckrodt's work under contract to the Atomic Energy Commission, are discussed.

For more details circle #668 on mailing card.

• **"Pittsburgh Fluorescent Equipment"** is the title of a new eight-page bulletin prepared by Pittsburgh Reflector Co., 476 Oliver Bldg., Pittsburgh 22, Pa. Designated **Bulletin Z,** it gives a comprehensive story of the new line of recessed modular light units introduced by the company, with complete specifications, dimensional data, photographs, tables and drawings providing the details on the various lighting units in the line.

For more details circle #669 on mailing card.

Suppliers' News

Automatic Electric Co. manufacturer of automatic telephone equipment as well as other electronic items, announces removal from **1033 W. Van Buren St., Chicago 7,** to its recently opened modern plant at **Northlake, Ill.**

G. A. Braun, Inc., 461 E. Brighton Ave., Syracuse, N.Y., manufacturer of commercial laundry equipment, announces building space that will increase production capacity by 80 per cent in its new plant annex.

Grant Pulley & Hardware Co. announces establishment of a **Hospital Equipment Division** under the direction of **Herbert F. Cupo,** for the manufacture and sale of hospital cubicle equipment and hardware. The new division is located at **69 High St., West Nyack, N.Y.**

Pullman Vacuum Cleaner Corp., 25 Buick St., Boston 15, Mass., manufacturer of commercial vacuum cleaners, announces the purchase of the **Grow Floor Machine Company of Burbank, Calif.** Production activities of the two-speed Grow floor machine will be transferred to the Pullman plant in Boston.

T & S Brass & Bronze Works, Inc., manufacturer of water dispensing units, announces the opening of its new plant and executive offices at **128 Magnolia Ave., Westbury, L.I., N.Y.**

SchenLabs Pharmaceuticals, Inc., is the new name given to the pharmaceutical affiliate of **Schenley Industries, Inc.** The new name was selected because it embodies the trade name by which Schenley pharmaceutical products are known and is more precisely descriptive of the company's function and business.

Service Appliance Co., Norwalk, Conn., announces the sale of all Peelmaster production and repairs to **The Silex Co., 3rd and Dauphin, Philadelphia 33, Pa.**

Knoll Pharmaceutical Company is the new name given to the firm formerly known as **Bilhuber-Knoll Corp., Orange, N.J.** This manufacturer of fine medicinal chemicals will continue its present policy of direct sales to hospitals and allied institutions.

Victory Metal Mfg. Corp., Plymouth Meeting, Pa., manufacturer of the Vimco, Sta-Kold and Sno-Queen lines of refrigerators, anunounces the opening of a new and modern research laboratory adjacent to the modern plant opened two years ago.

Welbilt Corporation, 57-18 Flushing Ave., Maspeth 78, N.Y., manufacturer of gas and electric ranges and air conditioners, announces the opening of its new **Garland manufacturing plant** providing advanced production methods for producing commercial cooking equipment. Complete manufacturing operations for Garland cooking equipment were moved to the new plant from Detroit.

INDEX TO "WHAT'S NEW

Pages 175-200

Key		Key		Key	
618	Cry-O-Therm *American Sterilizer Co.*	637	Hospital Humidifier *Walton Laboratories, Inc.*	656	Vesprin *E. R. Squibb & Sons*
619	Portable Room Conditioner *Carrier Corp.*	638	Disposable Shroud Garment *Busse Hospital Products*	657	"The Care and Handling of Gla Volumetric Apparatus" *Kimble Glass Co.*
620	X-Ray Control Panel *Standard X-Ray Co.*	639	Kard-Up Filing System *Remington Rand*	658	"What Every Executive Should *Massey-Young*
621	Intensifying Screen Book *E. I. du Pont de Nemours & Co.*	640	Water Heater *Ruud Mfg. Co.*	659	Space-Saving Files Brochure *DeLuxe Metal Furniture Co.*
622	Cat D375 Electric Set *Caterpillar Tractor Co.*	641	S/P Dextol *Scientific Products*	660	Laundry Planning Service *American Laundry Machine*
623	Artificial Kidney *Travenol Laboratories, Inc.*	642	Electric Food Warmers *The Bastian-Blessing Co.*	661	Catalog #13A *McKinney Mfg. Co.*
624	Kotostix *Ames Co., Inc.*	643	Waste Receptacle *The Bennett Mfg. Co.*	662	Catalog No. 9 *Graham-Field Surgical Co.,*
625	Hot-Pak Tray Server *Mealpack Corp.*	644	Ultrasonic Cleaning Unit *Acoustica Associates, Inc.*	663	"Food Service in The Modern Ho *Samuel Olson Mfg. Co., Inc.*
626	Tile with Waxed Surface *The Mosaic Tile Co.*	645	Duraco Vinyl Tile *Uvalde Rock Asphalt Co.*	664	Commercial Garbage Disposers *Waste King Corp.*
627	Aeroplast in Two Sizes *Aeroplast Corp.*	646	Bedside Floor Lamp *Faries Lamp Div.*	665	"Tips to Successful Maintenance *Seiz Corp.*
628	Disposable Vinyl Tubing *Becton, Dickinson & Co.*	647	Floor Wax *S. C. Johnson & Son, Inc.*	666	Data Sheet A-11 *The Wiremold Co.*
629	Pot and Pan Washing Unit *Easwanee Industrial Washer Corp.*	648	Steel Drawers *Equipto*	667	Bulletin 157 *The Spencer Turbine Co.*
630	Streamlined Showerheads *Kohler Co.*	649	Sterilamp G1075-½ *Westinghouse Electric Corp.*	668	"First in War . . . First in Peace *Mallinckrodt Chemical Work*
631	Model CPC 1520 Chair *Ajusto Equipment Co.*	650	Dishwashing Machine *United Mfrs. Inc.*	669	Bulletin Z *Pittsburgh Reflector Co.*
632	Colored Paints and Asphalt Roof Coatings *Aluminum Company of America*	651	Medic-Alert Bracelets *Medic-Alert Foundation*	847	Series "MA" Refrigerators *Kock Refrigerators, Inc.*
633	Versaline-Grid Troffers *The Miller Co.*	652	Self-Closing Drum Lid *The Witt Cornice Co.*	848	Movable Wall System *E. F. Hauserman Co.*
634	Whirlpool Bath *I. Blickman, Inc.*	653	Isuprel-Fromol *Winthrop Laboratories*	849	Beverage Cooler *J & J Products, Inc.*
635	Flex-Seal Cookers *Visher Products Co.*	654	Filmtab Gerilets *Abbott Laboratories*	850	Versatilt Blinds *C. R. White Co., Inc.*
636	Oxygen Therapy Mask *Ohio Chemical & Surgical Equipment Co.*	655	Arcofax *The Armour Laboratories*		

USE THESE CARDS

(We pay the postage)

I am interested in the items circled— **February,**

WHAT'S NEW				ADVERTISEMENT										
618	619	620	621	670	671	672	673	674	675	676	677	678	679	68
622	623	624	625	683	684	685	686	687	688	689	690	691	692	69
626	627	628	629	696	697	698	699	700	701	702	703	704	705	70
630	631	632	633	709	710	711	712	713	714	715	716	717	718	71
634	635	636	637	722	723	724	725	726	727	728	729	730	731	73
638	639	640	641	735	736	737	738	739	740	741	742	743	744	74
642	643	644	645	748	749	750	751	752	753	754	755	756	757	75
646	647	648	649	761	762	763	764	765	766	767	768	769	770	77
650	651	652	653	774	775	776	777	778	779	780	781	782	783	78
654	655	656	657	787	788	789	790	791	792	793	794	795	796	79
658	659	660	661	800	801	802	803	804	805	806	807	808	809	81
662	663	664	665	813	814	815	816	817	818	819	820	821	822	82
666	667	668	669	826	827	828	829	830	831	832	833	834	835	83
847	848	849	850	839	840	841	842	843	844	845	846			

NAME

INSTITUTION

ADDRESS CITY ZONE STA

...IEW"

...& Sons
...Handling of Glass
... Apparatus"
...s Co.
...ecutive Should Know"
...ng
...les Brochure
...al Furniture Co.
...ng Service
...Laundry Machinery Co.
...Mfg. Co.
...ld Surgical Co., Inc.
... The Modern Hospital"
...on Mfg. Co., Inc.
...bage Disposers Pamphlet
... Corp.
...ful Maintenance"
...ld Co.
... Turbine Co.
... First in Peace"
... Chemical Works
...llector Co.
...rigerators
...rators, Inc.
...ystem
...man Co.
...ts, Inc.
...Co., Inc.

INDEX TO ADVERTISEMENTS ON FOLLOWING PAGE

TO REQUEST PRODUCT INFORMATION
FOLD THIS FLAP OUT
AND USE THESE CARDS

(We pay the postage)

The two cards below are detachable and are addressed to us. With this flap folded out you can turn through the magazine for the items on which you want further information.

When, in either an advertisement or "What's New" you locate the product, turn to the index to advertisements on the following page or to the index of "What's New" items (left) where you will find the key number for the item. Items advertised are listed alphabetically by manufacturer. "What's New" items are in Key Number order. Circle the corresponding key number on the card below for each item in which you are interested. The second card is for the use of someone else who may also want product data.

Detach and mail — no postage required.

February, 1958 (b)

NT				
678	679	680	681	682
691	692	693	694	695
704	705	706	707	708
717	718	719	720	721
730	731	732	733	734
743	744	745	746	747
756	757	758	759	760
769	770	771	772	773
782	783	784	785	786
795	796	797	798	799
808	809	810	811	812
821	822	823	824	825
834	835	836	837	838

TITLE

STATE

I am interested in the items circled—

February, 1958 (a)

WHAT'S NEW			
618	619	620	621
622	623	624	625
626	627	628	629
630	631	632	633
634	635	636	637
638	639	640	641
642	643	644	645
646	647	648	649
650	651	652	653
654	655	656	657
658	659	660	661
662	663	664	665
666	667	668	669
847	848	849	850

ADVERTISEMENT													
670	671	672	673	674	675	676	677	678	679	680	681	682	
683	684	685	686	687	688	689	690	691	692	693	694	695	
696	697	698	699	700	701	702	703	704	705	706	707	708	
709	710	711	712	713	714	715	716	717	718	719	720	721	
722	723	724	725	726	727	728	729	730	731	732	733	734	
735	736	737	738	739	740	741	742	743	744	745	746	747	
748	749	750	751	752	753	754	755	756	757	758	759	760	
761	762	763	764	765	766	767	768	769	770	771	772	773	
774	775	776	777	778	779	780	781	782	783	784	785	786	
787	788	789	790	791	792	793	794	795	796	797	798	799	
800	801	802	803	804	805	806	807	808	809	810	811	812	
813	814	815	816	817	818	819	820	821	822	823	824	825	
826	827	828	829	830	831	832	833	834	835	836	837	838	
839	840	841	842	843	844	845	846						

NAME

TITLE

INSTITUTION

ADDRESS

CITY

ZONE

STATE

✚ ✚ ✚ INDEX TO ADV

FIRST CLASS
PERMIT NO. 137
SEC. 34.9 P. L. & R.
CHICAGO, ILL.

BUSINESS REPLY CARD
No Postage Stamp Necessary if Mailed in the United States

3 CENT POSTAGE WILL BE PAID BY

THE MODERN HOSPITAL
919 NORTH MICHIGAN AVENUE
CHICAGO 11, ILLINOIS

BUSINESS REPLY CARD
No Postage S

3 C

DVERTISEMENTS

FIRST CLASS
PERMIT NO. 137
SEC. 34.9 P. L. & R.
CHICAGO, ILL.

BUSINESS REPLY CARD
No Postage Stamp Necessary If Mailed in the United States

2 CENT POSTAGE WILL BE PAID BY

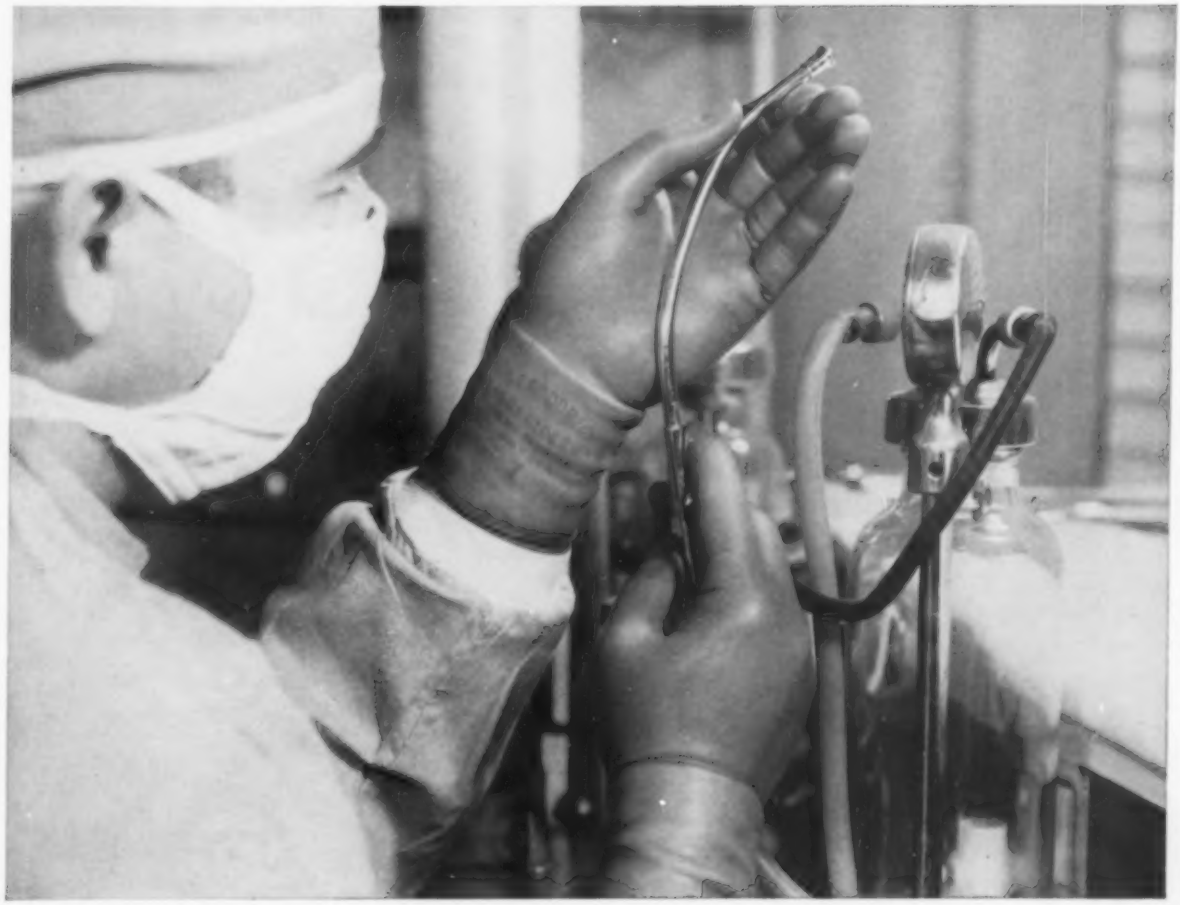
THE MODERN HOSPITAL

919 NORTH MICHIGAN AVENUE

CHICAGO 11, ILLINOIS

(HPF) after company name indicates that further descriptive data are filed in catalog space in Hospital Purchasing File—35th Edition.

B.F.Goodrich report:



More than 2300 surgeons are testing these "Surgiderm" gloves

Typical reports: "Much more comfortable", "Less tiring to hands"

At our invitation surgeons throughout the country are using and testing B. F. Goodrich "Surgiderm" gloves, and telling us how they fit, perform and last. The comments are still coming in, but already we can be sure that this new glove is being enthusiastically approved and accepted.

This approval is a guide to you in buying rubber gloves for your hospital. Surgeons like the new B.F.Goodrich "Surgiderm" glove because it is so much more comfortable than other surgical gloves. It is extremely sensitive to the touch, protective yet responsive to even the slightest movement of the fingers.

Comparison tests prove that the B.F.Goodrich "Surgiderm" glove is 30 to 50 per cent softer than any regular rubber surgeons' glove, including the brown cement type. Because it's softer and more pliable, it takes 25 to 30% less force to flex the fingers and hand, a tremendous factor in reducing fatigue.

In addition to comfort and sensitivity, this B.F.Goodrich glove is long lasting. It is strong to start with and stays strong even after many sterilizations. It is 36% stronger than a brown cement type glove *before* use, 67% stronger *after* ten sterilizations. What's more, it keeps its elasticity, can be stored for months with no danger of deterioration.

With this combination of comfort, strength and sensitivity, you'd expect B.F.Goodrich "Surgiderm" gloves to be expensive. Actually they cost no more than many standard gloves now on the market. They are made in sizes from 6 to 10, have rolled wrists which fit snugly over the gown, are brown in color. *Hospital and Surgical Supplies Dept., B.F.Goodrich Industrial Products Co., Akron 18, Ohio.*

B.F.Goodrich

Specify:

AMSCO

Model M·E·

RECTANGULAR STERILIZER

Features:

- M. E. construction . . . Monel End Ring welded to nickel clad interior for complete armor against rust or corrosion.
- Improved external appearance — easier to keep clean.
- Unitized Control Panel incorporates Indicating-Recording-Controlling Thermometer.
- Improved door hinge simplifies closing.
- Cyclomatic Control assures correct sterilization cycle with minimum operator time and attention.
- Vacuum drying keeps work area cooler and drier.
- Solution exhaust valve speeds cooling of flasked fluids.
- Exclusive steam-lock door assures complete safety.

American Model M. E. Sterilizers meet the modern need for large capacity steam sterilization of everything from surgical and obstetrical packs to treatment trays or flasked solutions. They have many specific features which make them easier, faster and more comfortable to use and less costly to maintain.

But the truly exclusive feature of the American M. E. is the integrity of design and manufacture which is summed up in the phrase "made by American Sterilizer." Only from that priceless ingredient can you derive the ultimate in convenience, efficiency and lasting economy.

Write for Bulletin SC-305

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

Offices in 14 Principal Cities